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ADULT CHARACTER AND BEHAVIOR DISORDERS

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There is a distinct and growing trend to veer away from the clinical designation of "psychopathic personality." The Army official nomenclature has included cases of this type under the more inclusive term of "character and behavior disorders" (1). This term, particularly the part referring to behavior, has in the past been used in describing childhood difficulties, but has now been extended into the sphere of adulthood.

We have become accustomed to accepting some *neurotic symptoms* in even normal people, but have failed to accept disorders of *performance* as gradients or variables of normal human behavior. In the past there has been perhaps too great a tendency to label individuals as psychopaths when their actions are not exactly in keeping with the greater mass of human society. Because psychopathy is considered to be a disorder of action, especially in the field of social relationships, and because these actions are often bizarre and unpredictable, some observers even believe these cases are suffering from true major psychoses. Cleckley (2) is apparently of this opinion. This view has not been generally accepted because of the contact with reality principle which is decidedly different in the true psychoses.

The question as to whether these abnormal personality types are suffering from psychosis is decidedly important from the legal point of view, because legally they must be looked upon as being fully sane and responsible. When looked at from the point of view of the physician, however, these people are ill and have little or no control over their socially unacceptable behavior. Moreover, when they are studied from the viewpoint of psychodynamics, one is less likely to fall into the trap of saying that they are psychopathic because of their behavior and then later say they behave that way because they are psychopathic.

The author has had the opportunity of studying for a period of almost two years 2,000 young adult males who were suffering from "character and personality disorders." These men had all committed military offenses of sufficient severity to warrant long confine-

ment by U. S. Army General Court Martial. The U. S. Disciplinary Barracks, Fort Missoula, Mont., was established as a medium security installation. The severest problems, which required maximum security, were sent to other places. The population ranged at all times from a minimum of 1,200 to a maximum of 1,600 inmates. At our post the men experienced group living and were not kept in individual cells, except for short periods for disciplinary purposes. A diagnostic label of "psychopathic personality" had been placed on nearly every one of the cases by a psychiatrist at the time of the General Court Martial or after having spent some time at a Rehabilitation Center. The more hopeful cases were sent to the Rehabilitation Centers and usually were restored to duty from there, but if after they were considered not restorable, they were transferred to a Disciplinary Barracks. Study of the cases showed that at least 70 per cent of the men met all the former criteria for a diagnosis of "psychopathic personality." The others fell into groups which were considered feebleminded, psychoneurotic or "essentially normal." This last-mentioned group was purely relative in most instances, because it consisted of men who were sent back to duty without the stigma of a diagnostic label. A fair proportion of these cases again committed military offenses after their return to the colors.

The total impression created by working with these cases is not the similarity of their make-ups, but rather their differences. Many authors draw a picture of a particular type of "psychopath" with a special family background and draw conclusions that that is the alpha and omega of the whole subject. Greenacre's (3) description of a particular type of problem was very well done. She points out that the performance of these individuals is characterized by impulsiveness and marked irresponsibility, intense, but labile emotional states and generally quixotic and superficial love relationships. They sign bad checks, marry on the spur of the moment, or impulsively run away from a marriage or a job. They appear to live in the moment, with great intensity, acting without plan and seemingly without concern for consequences. She points out, too, that homosexuality is inherent in the very structure of the personality. Her description fits the group listed as "emotional instability" and would probably also rate a further designation as "with asocial trends." This type of case is the aggressive, self-centered, impulsive person seen most regularly among military offenders. Two-thirds of the cases fell into this group. The other one-third consisted of a submissive, inadequate, somewhat withdrawn group which appear in the nomenclature as "schizoid personality reaction, inadequate personality, asocial, etc." The predominant feature in these cases is that of total inadequacy rather than social

aggressiveness. They may even show somatization reactions. Nosologically they are closer to the psychoneurotic group, but are considered here because of fixed patterns of performance which may become decidedly unsocial in certain settings. They fit into a submissive introvert group. Of this more will be said later.

A good many psychiatrists, who are willing to accept psychogenesis as the etiologic agent in psychoneurosis or even psychosis, are firmly convinced that "psychopathy" is an organic condition. Before we draw any conclusions as to either psychogenesis or purely physical determinism, let us examine the evidence for the concept that the condition is organic. Lombroso introduced the idea that there are definite physical characteristics in criminals. Unfortunately his types have not been substantiated by other workers and his contributions have fallen into discard. However, the thought that psychopaths are "constitutionally" different has been so firmly fixed that even such a distinguished neurologist as Foster Kennedy (4) adheres to this principle. He bases his contention, in part at least, on the fact that psychopaths do not respond to electroshock therapy. He states they do not respond because "one can only hope to reestablish the original endowment." Only recently has the term *constitutional* psychopathic state been replaced by the better, but not wholly satisfactory, term psychopathic personality.

If there is a "constitutional" difference there should be some other objective criteria of this difference. Although anthropometric studies were not made with the cases of this study, the casual observations have failed to disclose any physical differences. They are tall, short, thin and stout. They have short noses and long ones, they have large ears and small ones. Even "short arms" inspections are not different from the average run of males.

Exponents of the hereditary aspects of psychopathy point to the evidence of abnormal behavior in other members of the family. Such cases were seen in our study, but this does not in any sense point to heredity. As is so well known, unstable parents do not furnish favorable milieux for the children to develop. In order to apply true genetic principles to the evaluation of heredity as a factor in psychopathy, the exact manner of behavior would have to follow mendelian law. In other words, if stealing or aggressiveness were hereditary, these same acts would have to be chromosome-tied. Unfortunately most studies on the heredity of psychopathy include all aberrations of human behavior, e. g., psychosis, mental deficiency and alcoholism as evidences of "poor stock" or "hereditary taint" and forthwith use this to explain abnormal behavior on the basis of "bad constitution."

Slater (5) states that psychopathic personality is the result of a combination of hereditarily determined tendencies.

Workers have attempted to discover neurologic and encephalographic differences between psychopaths and normal individuals. In our series of cases, no neurologic differences were disclosed. This is essentially the opinion of other observers. The physical sign of "digital asynergia" described by Hodge (6) was not confirmed. The author found coarse tremors which appeared to be increased by hyperpnea, but attached no particular significance to the finding. As to encephalographic changes, however, there has been some difference of opinion. We were not so fortunate as to have an electroencephalograph available, but did have some reports on a few cases which were sent to a general hospital for observation. Only 1 case was reported as suffering from cerebral dysrhythmia of the psychomotor variety. This case had shown such bizarre behavior that he was sent to a general hospital with a diagnosis of psychosis. Many workers have described a high percentage of abnormal brain wave patterns in psychopaths and considered them to be cases of subclinical epilepsy (7, 8, 9, 10). Much of this work was done with behavior problems of childhood. Gibbs, Bacchi, and Bloomberg (11) appear to have dispelled much of the confusion on the subject by their study of 452 criminals. Their findings indicate that in their group of cases the so-called psychopaths do not differ electroencephalographically from a comparable age group of normal persons. Furthermore, the organicists have failed to prove that psychomotor brain patterns actually represent organic disease processes, but for the sake of argument no disagreement is offered. Darrow and co-workers (12) and Hodge (6) suggest that emotional disturbances can cause changes in EEG records. In any case, cerebral dysrhythmias do not constitute more than a negligible percentage of the cases which are considered psychopaths.

On the matter of intelligence the study of our cases shows some rather interesting results. On group and individual tests the total average intellectual level is somewhat below that of a comparable age group in the Army. Whereas the general average of the military population showed an AGCT score of 104.37 (13) with a standard deviation of 23.41, the inmate population showed an average score of 88 with a standard deviation of 24.6. This figure must be evaluated on the basis of the fact that about 1 per cent of the inmate population was diagnosed as clinically feeble-minded. Probably many of our cases had poorer educational backgrounds than the average soldier. Furthermore, their instabilities were such as to invalidate some of their scores. Where individual Wechsler-Bellevue tests were administered, a very large percentage of the inmates scored much higher

than they did on group tests, so the two figures, namely the Army average and the inmate average, became more nearly alike. Qualitatively, however, the test results proved very interesting.

A small group of cases was given the Shipley-Hartford Retreat Test. It was noted our cases showed a marked discrepancy between the scores obtained on the Vocabulary Age and the scores on the Abstraction Age. Shipley (14,15) originally described this phenomenon as one of deterioration, as he found this to exist in cases of advanced schizophrenia. He devised the formula $\frac{AA}{VA} = CQ$, with CQ representing the "Conceptual Quotient." As a result of our observation, the study of abstraction was extended to a sufficiently large number of cases (125) to make the point more valid. It was found that one-half of the total number of cases (49 per cent), which represented a fairly true cross-section of the inmate population, showed a CQ of less than 80. This figure presumably represents a "quite suspicious" group. Table I shows the breakdown according to diagnosis and percentile distribution.

If one were to lean toward the organic aspects of psychopathy, it would be very convenient to say psychopaths are endowed with good verbal ability and poor abstract thinking purely on a heredity-constitutional or organic injury basis. This could easily explain how these people make nice superficial impressions, yet cannot think out problems adequately. This latter may be true, but blindly to accept constitutional differences closes the doors for further investigation. It is a well known fact that emotional disturbances can cause distortions of intellection, and therefore conclusions should not be hastily drawn from this finding.

Another bit of evidence for the organic aspects of psychopathy may be seen in the actual behavior of some of these cases. Impulsivity, explosive temper outbursts and shades of paranoid trends seem to be sequelae of known encephalitis and intracranial trauma. Probably an occasional case may fit into this category. The author failed to find more than a slight scattering of cases with difficult delivery, severe head trauma or febrile illness, which may have suggested encephalitis. On the other hand, one case which showed all the signs of the true psychopath had been diagnosed as postencephalitis during adolescence at a well-known child guidance clinic. Study of the case at our station failed to reveal any evidence for such a diagnosis.

The case for psychogenesis in our series is overwhelming. There is no need for the introduction of subtleties. Each case represented a story-book plot in the study of the family drama. Case after case repeated itself with monotonous regularity to such an extent that in

many instances the author was able to reconstruct the family background merely from the study of the symptomatology and thought processes of the individual case.

The 50 cases which are summarized for this presentation offer a few salient features of the emotional development of these individuals. They are entirely unselected. They are random cases of adult male character and behavior disorders having an AGCT score of above 70 to rule out the problem of mental deficiency. If time had been available, abstracts of the entire series of 2,000 cases could have been made. The author is certain that nothing would have been

TABLE I

DEGREE OF SO-CALLED DETERIORATION AS DETERMINED BY SHIPLEY-HARTFORD RETREAT SCALES IN 125 GENERAL PRISONERS

CONCEPTUAL QUOTIENT	Above 90	86–90	81–85	76–80	71–75	66–70	61–65	56–60	51–55	46–50	41–45	Total	% of Total
Essentially Normal	1	....	1	3	....	1	....	2	....	....	....	8	6.4
Social Deviates	1	1	....	1	2	....	....	....	....	2	....	7	5.6
Asocial and Amoral Trends	2	....	2	....	....	1	1	....	....	....	....	6	4.8
Emotional Instability	15	4	4	0	3	3	1	1	....	....	....	41	32.8
Emotional Instability, Alcoholism	1	....	....	1	1	....	....	....	....	....	....	3	2.4
Emotional Instability and Other	1	....	1	....	1	....	1	....	....	....	....	4	3.2
Inadequate Personality	9	4	3	6	2	4	....	....	....	....	....	28	22.4
Inadequate Personality, Alcoholism	....	....	....	1	....	....	....	....	1	....	....	2	1.6
Inadequate Personality and Other	1	....	....	....	....	....	....	....	....	....	....	1	.8
Alcoholism	3	....	....	....	....	1	1	....	....	....	....	5	4.0
Psychoneurosis	2	1	1	2	1	....	....	1	....	....	....	8	6.4
Schizoid or Paranoid Personality	3	1	....	2	....	3	....	....	....	....	....	9	7.2
Other	....	....	....	....	....	1	....	1	....	....	....	2	1.6
Psychoneurosis with Alcoholism	....	....	....	....	....	....	1	....	....	....	....	1	.8
TOTAL	39	11	12	26	10	14	5	5	1	2	....	125	....
PERCENTILE	100	68.8	60	50.4	29.6	21.6	10.4	6.4	2.4	1.6	....	....	....

gained from this, as nearly all the case histories were well-known to him, but were merely not tabulated for this statistical study. These 50 cases so characteristically support the impressions gathered by working with the entire series that it was not felt that abstracting more cases would materially add to the findings.

By reading the cases one can see how nearly all of them show gross disturbances in the home. Separation, divorce, alcoholic parents, and disturbed parental attitudes run through the histories with shocking regularity. The following table shows the breakdown for these gross background abnormalities. There is, of course, much overlapping as some cases fall into more than one category.

Table II shows the cases divided arbitrarily into two groups. In

TABLE II

DISTURBING ELEMENTS IN ENVIRONMENTAL BACKGROUNDS OF 50 UNSELECTED CASES OF ADULT BEHAVIOR DISORDERS

	Number of Cases	Percentage
Divorce or Separation (Before 12 years)	9	18%
Divorce or Separation (After 12 years)	1	2
Alcoholic Father	12	24
Punishing Father or Stepfather	5	10
Deserted by Father (Before 12 years)	2	4
Nervous or Ineffectual Father	13	26
Death of Father (Before 12 years)	9	18
Death of Father (After 12 years)	5	10
Punishing Mother or Stepmother	4	8
Abandoned by Mother	0	0
Rejected by Mother	8	16
Nervous or Ineffectual Mother	17	34
Death of Mother (Before 12 years)	4	8
Death of Mother (After 12 years)	2	4

one group were placed all of the submissive, inadequate individuals and in the other group were placed the aggressive, antisocial individuals. It will be noted that in both groups there was a preponderance of cases in which there existed some sort of problem in relation to the father. Whether or not this finding would be true in the study of a comparable number of female cases cannot be answered at this time. But in any case it is an empirical finding and represents the crux of our study.

Although there are listed four homes which were described as "normal" homes, the indications are this was certainly not the case. However, the histories do not have any information to the contrary, and the author is willing to make a concession in this direction for scientific argument. These cases appear in the protocol as Case Nos. 4, 7, 8, and 29.

Only one case (No. 46) suggests brain pathology as a possible cause for the abnormal behavior. But even here emotional forces were sufficient to explain the behavior without hiding behind the cloak of alleged organic pathology. Other than the aforementioned "normal" homes there are recorded only two instances in which there were normal fathers. In those instances the records show that the problems in the home existed exclusively with the mothers. This is in marked contrast to the series of cases of anxiety state in children previously

TABLE III

CORRELATION OF ENVIRONMENTAL INFLUENCES AND PERSONALITY TYPES IN THE STUDIED GROUP

TYPE OF HOME	INADEQUATE IMMATURE		EMOTIONALLY UNSTABLE AGGRESSIVE	
	Number of Cases	Percentage	Number of Cases	Percentage
Presumably Normal Home	3	18.8%	1	2.9%
Father Problem	4	25	11	32.4
Mother Problem	1	6.2	1	2.9
Both Parents Problem	8	50	21	61.4
TOTALS	16	....	34	....

reported jointly by the author (16), in which nearly all of the mothers were found to be pathologic. As to the question of distortion of facts this is hardly likely to be true. Although very few parents were actually interviewed by us, the statements made by the subjects themselves were nearly always confirmed by Red Cross histories.

In contrasting the inadequate group with the aggressively unstable group, it appears that in the former 75 per cent of the cases showed father problems, and in the latter this was true in 95 per cent of the cases. This preponderance of father problems in the aggressive group was checked statistically. Calculated on the basis of the number of cases presented, this shows a critical ratio of 1.64. This means 95 out of 100 similar studies would show a comparable trend. In both groups, however, the largest number fell in the category of having problems with both parents. This indicates that even having one adequate parent acts as a stabilizing influence upon the emotional development of the child. But when both parents fail to carry out their missions in relation to their offspring, then the results are disastrous. If we were to add to these gross abnormalities the subtleties of such items as veiled rejection or compensatory overprotection it can be seen how unhealthy were the emotional climates of our cases. In addition, cognizance must be taken of the fact that our cases were not the severest problems. The so-called "severe psychopath" was not kept for any length of time at our station.

Study of the protocol reveals clearly that the symptomatology of our cases began in childhood. The childhood patterns fall into two natural groups: aggressiveness or submissiveness. Either they were behavior and conduct problems as children from the point of view of family and community life or they were nervous, anxiety-ridden children who were mainly problems to themselves. Table IV shows that of the 50 cases, 21 cases were aggressive and 29 cases were nervous as children. It also shows that of the emotionally unstable (aggressive) adults, 61.9 per cent were aggressively misbehaved children and 24.1 per cent were classified as having been nervous children or personality problems. On the other hand, none of the cases described as inadequate personalities had been aggressive as children. They all fell in the nervous group. The other cases were scattered just about evenly between the aggressive and submissive groups. This means that nervous children can either become inadequate adults or can become problems in aggression, but that aggressive children are not likely to become withdrawn, inadequate people. In this respect then, aggressiveness is a healthier symptom for the individual than submissiveness, but may not be as acceptable to the people around him. Of this more will be said later in discussing the psychodynamics.

Although the literature is already replete with descriptions of the so-called psychopath, it is felt a few remarks in this respect may be helpful, particularly inasmuch as we had the opportunity of getting Rorschach reports on so many of our cases. Unfortunately, all of the cases in the 50 case study did not receive this test, but the tests were given to many other subjects not included in the study and comparable results were obtained.

There is one element in the personality configuration of these individuals which runs true to form in all of these cases, and that is the element of narcissism. These cases are essentially wrapped up in their own problems. The inadequate individual presents the picture of the submissive introvert described by the author in another publication (17). The other cases present the picture of the aggressive introvert. The difference exists mostly in the realm of "feeling" in contrast to "action," or, as will be pointed out, it is a question of symptom versus character or conduct disorder. In this connection it may be repeated

TABLE IV

CORRELATIONS OF CHILDHOOD PERSONALITY PATTERNS WITH ADULT REEACTION TYPES

DIAGNOSIS	AGGRESSIVE DURING CHILDHOOD		NERVOUS DURING CHILDHOOD	
	Number of Cases	Percentage	Number of Cases	Percentage
Emotional Instability	13	61.9%	7	24.1%
Inadequate Personality	0	0	14	48.3
Emotional Instability, Chronic Alcoholism	2	9.5	4	13.8
Asocial Trends	3	14.5	3	10.3
Aggressive Reactions	1	4.7	0	0
Emotional Instability, Drug Addiction	1	4.7	0	0
Alcohol Addiction	1	4.7	1	3.4
TOTALS	21	100 %	29	100 %

that the inadequate individuals are more disorganized than the aggressive individuals and are closer to or may be part of the psychoneurotic group. The narcissistic trait is sometimes revealed objectively by the responses in the Wechsler-Bellevue test. These individuals exhibit difficulty in abstract calculation, but when their personal needs are threatened they do well. For example, they readily perform problems in coin changing, because this concerns their own personal needs. These people are generally very impatient. They also exhibit very little depth in regard to human relationships. They have the tendency to put into action some of their inner drives. The aggressive group, however, is more characteristic in this respect than the inadequate group. The difference lies in the fact that the aggressive patterns are motivated more by a predominant emotional tone of anger, whereas in the inadequate group the motivation is mostly that of fear.

The Rorschach reactions reveal evidences of impulsivity and sensitivity to slight external pressures, particularly in the aggressive group. In addition, they show little range of interests with little digression from their own central themes. Elements of perversity and suspiciousness are also noteworthy features. The withdrawal group shows some difficulty in handling reality with a distinct tendency to draw away. They may show intellectual capacity to pay attention to details, but their responses are often bizarre. In this regard their intellectual capacities give them little protection from stresses because their emotional instability lowers their mechanisms of control. Hence they act without the exercise of good judgment. It is this very phenomenon which was demonstrated in the Shipley-Hartford test results which can be adequately explained on the basis of acquired emotional distress rather than constitutional organic differences. In general, the Rorschach findings in our group of cases were similar to those described by Lindner (18), except that he did not differentiate between the aggressive and submissive groups and reported findings which appear in either one group or the other, but not in both.

The superficial, confused social relationships exhibited by these individuals are but a reflection of the confused relations in the family frame of reference. On the aggressive level they are people who are caught in the whirlpool of the vicious cycle. As they feel insecure they react with aggression. This seems to incur further hostility and they react further, and so on. This vicious cycle repeats itself many times. It occurs in school and at work. In our cases the vicious cycle repeats itself in the Army and in confinement. This matter was discussed in a previous publication (19).

Fixed personality or conduct patterns arise out of the fact that sometimes in the course of the "acting out" the individual has gained

a measure of satisfaction out of his actions. This satisfaction may have come merely from the release of physical hostility or from unlawful gain such as stealing. It may have been an escapist type of pleasure as in the case of the alcoholic or drug addict, or, as in the case of the sexual pervert, pleasure may be gained by gratifying infantile forms of sexual cravings. The body protects itself against the frustrations of unmet demands, but gains equilibrium by getting gratification out of new demands even though they may not be socially acceptable from our sense of cultural values. The personality then crystallizes around the matrix of abnormal forms of gratification in an ego syntonic manner.

Such people do not attempt to maintain tensions for any length of time because they have learned to gain satisfaction out of the immediate release of their impulses. These impulses are under very poor control because there has not been established an adequate super-ego structure. This faulty super-ego has been the resultant of disturbing forces within the family frame of reference.

Before embarking further on the subject of disturbed child-parent relationship, let us mention that even from the most superficial observation, it is apparent that there exists a conflict on the masculinity-femininity issue. Nothing irritates the aggressively unstable male more than to cast aspersions on his masculinity, except perhaps some insulting allusions to his mother. In this connection the sex lives of these men are just one notch above homosexuality. In confinement they often engage in homosexual activities, with aggressive types in the masculine role and the submissive types usually in the feminine role. Some insight into their sexual drives is garnered from some of the invectives used at each other, particularly by the Negro inmates. The worst insult is that of referring to a man as a "mother f—." This is known as "puttin' a man in the dozens." They protect themselves against the incestuous implications by saying this refers to any woman who has had a child; it might even mean a man's own wife. This in turn is a rather transparent indication of the close association that "wife" and "mother" have in these people's minds. It is only natural then that these men marry repeatedly and obtain their greatest gratifications outside of their own marital relationships.

There is a distinct paranoid element in our cases. These men do not relate themselves to authority. They show varying degrees of rebellion against authority, fear of authority, or denial of the existence of any authority. All authority represents the elusive "they" which has been described by many writers and which was discussed by the author in a previous publication (19). The "they" represents the other side of the fence to them. Suspicions, mistrust, and fear of

being wronged, help to maintain the wide social distance that these cases have from the society of normal people.

The author was impressed with one outstanding clinical fact. In not one of the 2,000 cases which were considered problems in adult behavior (aside from the mental deficiency group) did the author find a case where a man had made a wholesome identification with a father-person. When one realizes that nearly all of the cases had some type of problem-father, the reason for this failure to make an identification becomes more apparent. The fact that so few of the inmates were able to make a wholesome identification with the father-person is the main reason that so few were recommended for honorable restoration to the colors.

The whole subject of identification is worthy of some discussion. This phenomenon is not entirely clear, judging by its frequent misuse. When an expression appears in the literature, as has happened recently, that the "infant identifies itself with the mother," it should not mean the same as that the "infant loves the mother." The infantile or primary process of identification merely means that the infant learns to evaluate the emotional experiences of the people around him after he has experienced these emotions himself. Expressed differently, he establishes a cathexis upon the object with his own narcissistic libido. When his mother smiles, he knows she is pleased, because that is the way he feels when he smiles.

The phenomenon of secondary identification, which is what we generally refer to when we speak of identification, is somewhat different. It occurs later in the life of the child and takes the place of an object relationship. The love that the child expresses for his parent results in his incorporation of the qualities of his parent into himself and becomes part of his own personality. Or, to use the language of Freud, the object-libido is displaced on to the ego. Thus the object is no longer merely a part of the external world, but becomes part of the individual's own ego structure. This in a sense makes the child independent of the parent. However, new energy arises from this source and becomes the fountainhead for the ego ideal and later the super-ego. In this way the child behaves unconsciously as the parent wishes him to or as he knows the parent would behave under similar circumstances. This form of identification, in the case of the male derives its greatest energy from the mother during the oedipal phase and from the father after the abatement of the hostility.

In the series of cases reported in this presentation there was either the presence of still raging hostility against parental authority

or society, or there was an identification with an unwholesome type of masculine symbol. The hostility did not seem to be a primary cause-and-effect relationship consisting of simple frustration and its consequent aggression. Instead there is clearly the interposition of the presence of anxiety. In rarer instances there was noted some evidence of depression. These manifestations in no way differ from those seen in the psychoneurotic symptom picture. In the so-called psychopath, however, aggression acts as a defense mechanism which almost frees the person from anxiety or depression as long as he can give vent to its expression. What happens is that the anxiety-ridden individual borrows sadistic qualities from the infancy period (both oral and anal in type) and develops a personality which can circumvent most of the tensions. This aggressiveness is then secondary to anxiety and is not a primary reaction to frustration.

Another factor in the behavioral problem is the super-ego. To say that they have no super-ego is decidedly erroneous. But to find the super-ego completely compartmentalized or isolated in a part of the personality which usually only deals with individuals like themselves is more in keeping with the facts. The so-called "honor among thieves" is a case in point. Actually the more disturbed individuals are more completely narcissistic and only exhibit a cooperative spirit with others like themselves when it gives them some personal gain.

Both the unresolved aggressions and the faulty super-ego structure are concomitants of the failure to make the proper identifications with the parent person of the same sex. It is a known fact that no man enters the portals of maturity until he has made a healthy identification with such a parental figure.

Some writers consider the psychopath to be suffering from such a severe disorganization of the emotional processes that he is to be classed with the psychoses. Wittels (20) states that the psychopath has a fixation in the pre-oedipal phase of psychosexual development, that when he shows neurotic manifestations it means that there is a second fixation point in the oedipal phase. This means that the neurotic manifestations are of a higher order than the behavioral manifestations. It is upon this point that the author is offering some disagreement because of deductions from the case material studied. However, if Wittels is talking of a different type of case, then the whole subject becomes further confused.

Wittels propounds the notion that the psychopath exhibits a manner of performance similar to the stage of development which corresponds to Jones' "protophallic phase." He offers as evidence

the fact that these cases do not know the meaning of paternal authority and also have no particular respect for their mothers. He says that the reason that such cases "act out" is because they have not as yet become aware of the pending Oedipus conflict and the father authority which later becomes the super-ego. He also makes the statement that such cases have never passed through the phase of castration anxiety. It is the author's opinion that the type of "acting out" which Wittels describes belongs either to the hypomanic type of performance or to the group of cases referred to as "schizophrenic character." Such cases, of course, do exist, but are beyond the scope of the presentation.

Our cases clearly show that a large portion of the men went through phases of clear-cut anxiety symptoms in childhood. One case stands out in the mind of the writer; it is not one of the cases in the protocol. This man was one of the worst cases of aggressive and asocial behavior that the writer has ever seen. He had a brutal hostility which led to several serious assaults on other inmates; he ruled over the other men with an iron hand and perpetrated a series of dangerous aggressive escapes. His history showed that he had been a fearful, anxiety-ridden child. Up to the age of 18 years he looked under his bed every night before retiring. His body grew strong and powerful, and he discovered that he could use it to advantage. He became a professional sparring partner, and from that time on there was no holding him down. In a few years he accumulated a long police record for his aggressively asocial acts.

The author does not disagree with Wittel's observation that the meaningfulness of parent persons is weak in these people. But this weakness of parental influence is also a manifestation of the latency period. It is the author's contention that adult behavior difficulties represent complete arrest of psychosexual development in the latency period. Hodge (6) makes a similar statement. He suggests that in the compulsive psychopath we are observing a condition where the normal establishment of corticothalamic association patterns is arrested at the age in childhood corresponding to the end of latency and the beginning of homosexual periods. There are many similarities between the normal latency period and so-called psychopathic behavior. In this period the libidinal ties to parental figures are weak, there is a strong homosexual component, and there is great loyalty to the group (the gang). It is the stage when there are secret codes and language to keep out the prying eyes and ears of the parents (the authority).

There are probably a few cases which may fit into the preoedipal fixation group, but the author does not feel that they represent the

majority of so-called psychopaths. The cases of wild, unrestrained children who spent their first years of life in institutions, as described by Lowrey (21) and Goldfarb (22), did not play a prominent role in our cases. This group, if unmodified by changed environmental influences, may fit into the group of "protophallic psychopaths" described by Wittels. It is the author's contention that the bulk of adult behavior cases consists of individuals who have attempted to resolve the oedipal ties, but they could not do so because of lack of adequate paternal symbols with whom they could make wholesome identifications. Such people are not free to mingle as mature adults because the normal adult world is strange and foreign to them. They have not incorporated into their personalities the necessary attributes of well-functioning adult masculinity.

The overt male homosexual makes a compromise with his inability to identify himself with his father. Because of his repressed hostility and manifest fear, he is driven away from his father. His maternal identification becomes intensified and he even assumes the role of the woman. In this way he can control the paternal symbol through the medium of offering himself as the recipient of the masculine sexual advances of the father image. The inadequate, submissive adult has a greater component of the above-mentioned homosexuality than the aggressive one.

Almost any symptoms may have either an aggressive or a submissive modality, as, for example, stealing. The aggressive hold-up man does not think that strong arm robbery is actually stealing. He condones his behavior because it is a face-to-face relationship. Sneak thievery, however, is essentially a submissive symptom. The author has the impression, not statistically confirmed as yet, that the aggressive robber began to steal from his father as a child, whereas the sneak thief began his stealing by pilfering from his mother. The unconscious motivations represent hostility in the one case and searching for maternal love in the other. The Talmud states the robber (gazlan) is to be more respected that the thief (ganov).

There is a distinct relationship between what is referred to as symptom formation and behavior or character formation. The neurotic or inadequate person is motivated largely through his own primary narcissism and gives way to bodily reactions. The aggressive person who "acts out" releases his inner conflicts in some form of overt behavior and has less need to complain of his own discomforts. This relationship of low incidence of somatic complaints in the aggressive group and a high incidence of complaints in the inadequate group has been confirmed by many workers in the field. It is as if the indi-

vidual gets into external trouble in order to avoid internal trouble. The growing use of the term "character neurosis" for behavioral abnormalities is a salutary one and could well replace the less desirable "psychopathic personality," but to drop the term neurosis completely and merely refer to it as a behavior disorder of adults seems even better.

The true picture of the personality structure of the individual who manifests an adult behavior disorder is one of the least understood from the viewpoint of dynamic psychology. Perhaps it is because of this lack of understanding that even the most sympathetic workers are drawn into the trap of venting their own aggressions by employing the designation "psychopath." The trend of not considering behavior disorders of *childhood* as manifestations of psychopathy has been under way. Similarly, *adult* behavior disorders should not be looked upon as anything beyond human comprehension. The fact that they cannot be readily modified by our present therapeutic methods does not militate against appreciating the fact that these individuals have personality organizations which may be more nearly like normal individuals than are the psychoneurotics. But obviously they are not normal people and are even different from those adults who are getting well from neurotic disorders. However, in this respect, mention should be made of the "acting out" that neurotics do during the course of analysis. Similarly, withdrawn, submissive children show aggressive manifestations as their guilt mechanisms are lowered during the course of psychiatric treatment.

The behavior problem adult can gain some satisfaction out of life, albeit pathologic. The neurotic, on the other hand, suffers and only seems to enjoy his suffering. The character disorder puts thought into action and derives pleasure from his actions. The neurotic gains little or no satisfaction from overt performance. When he does, he is labelled a psychopath.

Fenichel (23) terms the cases described in this presentation as "impulse neurosis." He shows that these cases are essentially different from compulsion neurosis in that the former are drawn in the hope of achieving pleasure whereas the latter usually perform painful acts in the hope of getting rid of pain. He states that these individuals are intolerant of tensions, requiring instant gratification of their desires. However, he contradicts himself later to some extent by saying that the aim is not pleasure, but the discontinuance of pain. He considers these cases predominantly oral fixations, expressing the formulas "I will give nothing because nobody gave me anything" or "I give to

no one to show that I am no more generous than my parents were to me." Because of their oral fixations, says Fenichel, they tend to react with violence to frustrations.

The essentially weak ego structure becomes evident when the impulses are forcefully curbed by the artificial limitations imposed by an understandably intolerant society. When the person cannot "act out" any longer, as in the Army, or particularly when placed in confinement, he may become overwhelmed. The impulsive behavior which acted as a defense mechanism is forcefully abandoned when the individual is placed in confinement. As a result, the clinical picture of anxiety or depression comes to the surface. Superficially the feeling tone of depressiveness lurks in all the corners of the penal institution. Much of this is due to the lack of freedom itself, but a share of it is due to a return of the preexisting depression that had been the motivating force for producing the behavioral difficulty. Violent nightmares and somnambulism also become characteristic features of some of the men in confinement. When the tensions reach a breaking point a true clinical picture of a psychosis may develop. These psychotic reactions are entirely different from the chronic psychoses that develop out of the submissive, schizoid personality types. These so-called "prison psychoses" are seen when such persons can no longer gratify their needs in the way that to them had been pleasing. The contact-with-reality principle sometimes seems to be so intact in these people that suspicions of malingering are frequently levelled in their direction. In order to help clarify this issue, the author revived a test which he employed some years ago for determining the emotional reactions of psychotic individuals (24). Several cases of general prisoners from overseas who were evacuated to this country because of psychosis were tested. None of these cases showed evidence of psychosis at the time of the test. Nevertheless, none of the cases tested the same as normal persons. One case showed a preponderance of annoyance without any other reactions, namely, defense, amusement and curiosity. The other (8 cases) showed considerable annoyance, very strong defensive reactions and little amusement or curiosity. True psychosis, it will be recalled, showed little or no emotional response in any of the categories, whereas normal persons react in a lively way to each of the emotional modalities. Conclusions drawn by the author point to the fact that these individuals are replete with aggressive impulses, but give way to fear when the aggressions cannot gain an adequate expression. When the fear becomes overwhelming, loss of reality control becomes temporarily manifest. Those cases which have the more poorly organized ego structures cannot with-

stand this limitation on their free expression of their drives and lose control of reality.

Although none of the cases was subjected to prolonged penetrating analysis, the study of the clinical material can be coordinated with fairly acceptable psychoanalytic principles as to offer some insight into the unconscious processes of the cases.

As pointed out previously, our cases seemed to be problems in identification. The distortion of identification may lead to aggressiveness because of the identification with hostile, rejecting parental figures, so that the super-ego permits aggressiveness as a regular mode of behavior without loss of economy to the self. Or, as Berliner (25) points out, they misbehave in order to give their parents good reason for hating them. Being unwanted, rejected children, these individuals lower their own values as love objects and fail to conform to the normal society of people. Fenichel (23) says that there are aggressive types who want to procure by force the essentials that the wicked outside world withholds. It is as if there were a strong motivation to punish those who have punished them. The hatred or indifference to authority appears to be not only a patent expression of hostility to the father, but may be an expression of similar hatred of the mother. These hostilities which stem from the early pregenital frustration at the hands of their mothers result in an "acting out" process which takes form in a design which is that of the oedipal pattern. It is just as the wronged husband who finds his wife in bed with another man shoots the man and not his wife. The hostility against the mother person in a sense can be looked upon as a healthy phenomenon, as it accompanies the resolution of the oedipal conflict. But where the frame of reference is pathologic, the personality becomes socially distorted. Case after case was seen where the man was originally terrified and antagonized by a drunken father, but when he attained his majority he repeated in every detail the performance of the father. In fact, most of these sons tried to outdo their fathers by drinking more than they did. The same is true about other unwholesome end-results of the natural course of development, as for example, the criminal pattern of the child of a criminal father. This in a sense has been described as the "normal criminal" and differs materially from the majority of cases worked with by the author.

Submissiveness can be looked upon as the under side of the coin. It is a different, but thoroughly related, phenomenon to that of aggression. When the child gains no satisfaction out of aggressiveness and only finds himself farther and farther away from gaining love, he

begins to fear his own assertiveness. He becomes anxiety-ridden out of the conflict arising from his need to be loved and his aggressions against the ones who are denying him this gratification. The pattern of submissiveness becomes a fixed trait and leads to the neurotic adult pattern or the inadequate personality unless the inhibitory guilt mechanisms are resolved and the more wholesome aggressions are released.

Berliner describes the submissive individual as the one who hides under a bushel and makes himself the whipping boy in order to win over the love of his rejecting parents. He also states such people are stigmatized by unwantedness and bear the stigma as a means of gaining affection. When this submissiveness is carried to its extreme the individual converts his suffering into pleasure and thereby develops into the masochistic personality. Such individuals seem to gain gratification out of the ability to survive the ordeal of being unwanted and unloved. They seek help and try to earn an affectionate interest by attempts to expiate their guilty feelings. They cower under the lashes of aggression from their parental figures in order to win love. In the Army these inadequate people committed military offenses, not out of anger or aggressiveness, but out of fear. Dependent men deserted the service to be with their mothers or wives. Often they feared going home and went elsewhere, and thereby increased their difficulties. Their sufferings were justified in their minds because of their desire to escape the burdens of a rejecting world.

There is an admittedly poor prognosis in the treatment of the so-called psychopath or behavioral disorder. The reasons for this are quite apparent. Because of the fact that parental figures are not important, these people find it extremely difficult to form a meaningful human relationship. The closer the ties are to the mother, the more inadequate the person seems to be. That is why therapy seems to be more effective with this group because they are more likely to seek help than the aggressive individuals. Furthermore, when satisfactions have been obtained out of abnormal performances there is less likely to be any crying need for reaching out for help.

In order to prevent children from becoming adult behavior problems, the emphasis should be placed upon affording wholesome parental figures of both sexes. Boys need fathers very badly. When a father person is missing, there should be a concerted effort made by the mother to build up as favorable a picture of the missing father as possible. Too many mothers in our group described the

missing fathers as no-good so-and-so's who did nothing but bring misery to the family.

Before closing this discussion the author would like to cite a case which illustrates the principle of the salutary effect of identification with a parent of the same sex.

R. D. was a 23 year old white, former private, who was given a general court martial for assaulting and robbing a homosexual. He was serving a five year sentence. His background revealed he was the older of two boys of nearly the same age. He had been a very serious behavior problem in his childhood. He committed many acts of vandalism, was unruly, disobedient and destructive. He was sent away for a while to reform school. In the Army he took his responsibilities lightly and was given two special court martials for minor offenses.

During the early part of confinement he was surly, antagonistic and distant. He was diagnosed as "constitutional psychopathic state, emotional instability" at another station and was not recommended for clemency or restoration to duty. He was kept in an institution of maximum security for a period of about eighteen months. He showed an improved attitude and was transferred to Fort Missoula, a medium security installation.

While at that station he came to the author's attention. It was noted that his attitude was not at all the same as the one described in the original report. He seemed to show a genuine need to make changes within himself, readily discussed his problems and wanted to be seen as often as possible.

It was learned that during his period of confinement he completely reorganized his thinking. His father stuck by him closely, wrote to him often and encouraged him considerably. He disclosed the fact that he had always hated and feared his father because he thought his father had not liked him and had favored his brother. He was positive that if he ever got into real trouble his father would disown him. The fact that his father stood by him was a revelation to him. He continued to write to his father and improved his relationship to such an extent that his whole personality changed.

In spite of considerable administrative doubts, the author insisted upon recommending him for restoration to the colors. When last heard from, his efficiency report read "above average," and he was in line for promotion as a non-commissioned officer.

The foregoing is illustrative of the principle of identification in the post-oedipal level. He satisfied all of the criteria for the diag-

nosis of psychopath, but if he were fixed at a protophallic level it is hardly likely that he would have shown such a marked change of character with a minimum of therapeutic effort. There were other similar cases, but to cite them would be repetitious.

In conclusion, it may be said that efforts to work with adult behavior problems are not entirely without hope. The greatest effort must be directed toward getting the cases when they are still young and helping them form wholesome identifications with parents of the same sex, because this factor was shown to be the greatest single determinant in their abnormal performance. Being confined to an institution where the "acting out" can no longer be used as a defense measure brings these individuals closer to their anxieties and hence more amenable for therapeutic assistance. When they make more wholesome identifications with parent persons of their own sex, they are better capable of taking their places in normal society.

CASE SUMMARIES

Case No. 1. A 25 year old white, former private was serving a five year sentence for desertion followed by escape from confinement. He was of average intelligence. His diagnosis was psychopathic personality, emotional instability.

His father was a coal miner of low intelligence who was described as being dishonest and a liar. His mother was reported as having been in poor health, but attended her home as much as she was able. She was a nervous person and was "morally rotten." He had one younger sister and an older brother who was suffering from tuberculosis.

During his childhood he was constantly in trouble with his parents because of his "hot-headedness." He was openly resentful of parental discipline. During adolescence he cursed his parents if he was frustrated. He was mischievous and took little interest in his school work. At about the age of 18 years, he left home repeatedly.

As an adult he failed to hold a steady job, and supported himself by dishonest gambling. He did some drinking and resorted to the use of marijuana. He married, but proved to be a poor husband.

He did not mind being in the Army, but went AWOL when his wife contracted a bigamous marriage. Later he deserted the service ostensibly to be with his brother, who was presumably dying. His escape from confinement was caused because he "could not stand the unsanitary conditions." After he began serving his sentence he asked

to be returned to honorable duty but later changed his mind because of something that was said "in one of the offices."

The psychiatric evaluation was that he was an individual who harbored perpetual grudges. He was insecure and decidedly hostile. He had made no identification with a father person but instead evidenced such marked suspiciousness as to border on the paranoid.

Case No. 2. A 24 year old, Negro, former private was serving a five year sentence for going AWOL while overseas, taking a government truck with him and causing the death of another soldier by drowning when the truck overturned. His intelligence scores show an AGCT IV, 70; Wechsler-Bellevue score was MA 10.10, IQ 80. This places him in the borderline group. He was diagnosed as a psychopathic personality, inadequate personality.

His father and mother were divorced when the inmate was 6 months old. His father remarried and after that was out of the picture. His stepfather was distant but not abusive. The mother and children lived with his grandmother until the inmate was 8 years old when his mother remarried. She always was solicitous about the inmate's delicate health. He had 1 sister, and 1 brother who received a jail sentence for fighting, and was discharged from the Army for medical reasons.

The inmate was a sickly child, having "typhoid malaria" three times. He had pavor nocturnus, was easily frightened, and was enuretic up to the age of 16 years (the inmate claimed only to the age of 7 years). He did poorly in school for "physical and mental reasons."

As an adult he worked in sawmills. He started gambling at 18. As 19 he got into trouble for forgery of government checks and served time twice for this type of offense. He later sold liquor to an Indian. His own drinking habits were not excessive.

He had had no previous court martial. Although he was reported as being uncooperative and unable to accept discipline, he was considered an asset. He claimed mental confusion from atabrine at the time of his offense. He gambled with other inmates in confinement.

The psychiatric evaluation showed him to be quiet, soft spoken, and polite, functioning as a rather dull individual not able to compete on a normal social level. He satisfied an aggressive component with gambling (probably crooked), but was fundamentally dependent on his mother and lacking an adequate male paternal symbol.

The results of the Rorschach test described him as unstable, perverse, unable to handle environmental pressures, impulsive, and ag-

gressive. He had a destructive approach with strong oppositional trends, lacking inner control over his basic impulses, possibly over sexual perversion. The Bender test showed distorted thoughts and emotional flattening with performance similar to a schizophrenic.

Case No. 3. A 23 year old, white, former private was sentenced for ten years on a charge of desertion. His intelligence scores show an AGCT V, 63, which may be inaccurate; Wechsler-Bellevue score was MA 15.6, IQ 108. He was diagnosed as psychopathic personality, inadequate personality.

His father was a chronic alcoholic with little formal education. He was a poor provider who mistreated his wife and children and was sent to a correctional institution for beating his wife. Several uncles of the inmate were alcoholic. There were many arguments in the home, and his parents were divorced when he was 5 years old. From that time he lived with his father only part of the time. The remainder of the time he lived with his paternal grandmother, who was cruel, punitive and took him away from his mother. She was excitable, nervous, easily provoked, and overprotective when with the inmate. He had 1 married sister with whom he had incestuous relations when both were young.

During his childhood he was buffeted about, sometimes being in orphanages. He had many anxiety symptoms, including fear of dying, and was mortally afraid of his father and grandmother. He had many difficulties in school and ran away from placements.

After reaching adulthood he was a self-conscious person who deserted the CCC when he was taunted for having a "nervous spell." He joined the Army at the suggestion of his father.

While in the Army he drank considerably and had four or five attacks of delirium tremens. He was always uncomfortable with numerous somatic complaints. He rode the sick book, being hospitalized repeatedly for "nervousness."

A psychiatric evaluation describes him as a shy, withdrawn individual with a strong sense of inferiority, but with a distinct desire to be noticed. He was rather suspicious of authority and sought feminine protection—he was supported by a woman during the time of his desertion.

According to the Rorschach test his normal intelligence was severely hampered by his emotional instability. He had an aggressive, introverted personality. His approach to environmental pressures was impulsive and grossly sensuous; he was unable to meet them on an extrovertive level of adjustment and at the same time

channelize them with emotional stability. He lacked mature inner strength and had poor control over his basic drives. There was a definite trend of paranoid thought content. The Bender test showed that he had anxiety and immature regression. He made some attempt at abstract planning but it was consistently poor.

Case No. 4. A 23 year old, white, former private was serving a two year sentence for intimidation and taking money by force. His diagnosis was psychopathic personality, emotional instability. His intelligence scores according to the Shipley-Hartford Retreat Intelligence Scale showed a VA 14.3, AA 13.6, MA 14.

His father was happy and easy-going. He covered up for the inmate by withholding negative information. His mother was a dynamic and hard working woman. He had two older brothers and two young sisters. That he had normal relations with them is rather questionable.

As a child he was nervous, shy, and restless, and ran away from home. He tried alcohol and marijuana.

As an adult he was still restless, alcoholic, but had no criminal offenses.

He was married during his Army service but was still restless and wanted overseas service. He had a number of short AWOL's; he was worried about his wife and child.

The psychiatric evaluation shows that he had no strong masculine identification. His responsibilities loomed large, but he professed good motivations. He probably reacted to the authority of his mother, with a lack of a strong father ideal.

Case No. 5. A 27 year old, white, former private was serving a sentence of five years for absence without leave and desertion. The Shipley-Hartford test showed scores of VA 16.2, AA 12.5, MA 14.3, IQ 76. He was diagnosed as a psychopathic personality, emotional instability.

His father was a poor sharecropper who died when the inmate was 12, according to the inmate. Red Cross information proved that his father died when he was 2 and at different times there were 4 other men acting as father. His mother lived without benefit of marriage with at least 4 men and with all had children. She was presumably devoted to all her children, but could give no care to them because she worked. The inmate was the third of 4 children. He got along well until he was quite grown but "now they have no patience" with him.

During his childhood he was nervous, truant, and ran away from home three times. He was "a lovable child." He learned to drink at the CCC.

As an adult he married, had two children, but had no responsibility for he was a serious alcoholic. He "can't stand crowds" and drank to avoid being considered a sissy. He had many arrests for drunkenness.

During his Army life he had repeated offenses due to drinking. In one instance he forged a check when pressed for funds.

In the psychiatric evaluation he was described as being disorganized, with an inadequate make-up, and with a lack of a proper masculine ideal. He was motivated strongly to prove himself a man which in confinement took the pattern of a desire for restoration.

Case No. 6. A 32 year old, white, former private was serving a sentence on a charge of twenty-one days absence without leave, escape for nine days, and two car thefts. The Shipley-Hartford scores were VA 190, AA 181, MA 18.5, CQ 102. His diagnosis was that of psychopathic personality, emotional instability.

His father was a good clean tramp up to the time of his marriage, very lax in discipline. The inmate claimed his father was never interested in him. His mother was a nervous and highly emotional person. The inmate was the oldest of 4 living children, and the sibling adjustment was reasonably good.

The inmate was described in his childhood as a hot-tempered, hard to manage, mischievous boy, attached to another boy of undesirable character. His school conduct was a problem. He was guilty of aggressive stealing and was a reform school runaway.

As an adult he gambled away much time in pool halls. He did some drinking and tried marijuana twice.

While he was in the Army he married and was divorced, after his AWOL's. He did unauthorized parachute jumps, to show that he was not scared to be a paratrooper. He held up a gasoline station on the last AWOL.

His actions were carefree and suicidal because he felt his parents never cared what he did. In his search for a masculine symbol he made a good transference to the post chaplain.

According to the Rorschach test he was emotionally unstable and immature. In spite of his above average IQ he had uncontrolled inner drives. He reacted with negativism, impulsivity—"a little guy doing a back flip." The Bender test showed emotional liability, negativism and a compulsive trend.

Case No. 7. A 34 year old, white, former private was sentenced to serve ten years for desertion. His intelligence tests showed an AGCT score of 71. He was diagnosed as a psychopathic personality, emotional instability (alcoholism).

His father was an elderly man of 90 who was strict but fair. His mother was a good, hard-working woman of 80. The inmate was the eighth of 11 boys, all of whom drank.

The inmate had a precarious physical development as a boy.

As an adult he was not only quick tempered but he held his grudges. He began drinking at 17 and had much trouble with the police for larcenous tendencies under the influence of alcohol. He was married twice.

The reports of his life in the Army were somewhat contradictory. He was described as being resourceful, aggressive, confident, and sullen. He left the Army to take care of a new baby.

The psychiatric evaluation showed a good performance when in confinement, but he lacked sufficient organization to handle his affairs when left free to do so.

Case No. 8. A 27 year old, white, former private was sentenced to five years for absence without leave to shirk maneuvers. He was diagnosed a psychopathic personality, inadequate personality, chronic alcoholism. His AGCT test showed a score of IV 69.

His father was a hard working railroad engineer who was devoted to his family, and his mother was presumably very adequate. He had 3 older brothers and 1 younger married sister, with whom he alleged to have had good relationship.

During his childhood the inmate was withdrawn, and stayed at home a good deal. He was often truant from school.

As an adult he married a woman who was unfaithful to him and he, too, was sexually promiscuous. He started drinking when he was 16, and was a state prison inmate for robbery and a few drunk arrests. He changed jobs frequently.

In the Army he was absent from duty often because his drinking interfered. He was once homesick, and he heard once that his wife was "stepping out."

In the psychiatric evaluation there is no evidence from the family history to explain his behavior. His attempts to compensate for a rather seclusive make-up resulted in a drinking pattern which later led to social complications.

Case No. 9. A 20 year old, white, former private was sentenced

for five years for insubordination. The diagnosis of his case was psychopathic personality, aggressive reaction. His intelligence scores are not known.

His father was a hard working, heavy drinking man who was hospitalized for chronic tuberculosis. He was a nervous person with a bad temper. His mother was rather high tempered but reasonable. The inmate had 5 younger brothers and 1 younger sister.

The inmate was into repeated trouble because of his bad temper as a boy. He went to a school for problem boys, but was later removed from this special school.

As an adult he abhorred monotony and was unable to take orders from his employers. He was never arrested in civilian life.

In the Army, too, he had difficulty in taking orders, and got into trouble because of his impertinent attitude. While in confinement he had the same difficulties, and worried greatly about his father's tuberculosis.

The psychiatric evaluation showed a rebellious, aggressive attitude to constituted authority. He had an ambivalent attitude towards his father, unresolved aggressions with some signs of beginning identifications (e. g., his father's temper).

Case No. 10. A 35 year old, white, former private was serving a five year sentence for insubordination. He was diagnosed as a psychopathic personality with asocial trends. His intelligence scores are unknown.

His mother died when the inmate was very young. His father remarried several times, but the inmate never got along well with his stepmothers. He was the youngest of 4 children, all boys. The other boys were all step-siblings. There is no record of their specific relationship.

In his childhood he ran away from home at the age of 11 years because of an inability to get along with his family.

He got into difficulty when he was an adult because of numerous acts ranging from fighting and vagrancy to grand larceny. He violated parole, went to Alaska and settled down in business.

He first resented induction into the Army because it interfered with his business plans and because he was obliged to sustain a financial loss. He was disgusted and adjusted very poorly.

In his psychiatric evaluation he was found to lack maternal affection. He had failed to identify himself with suitable parental figures, and his superficial adjustments were not maintained.

Case No. 11. A 22 year old, white, former private was serving a life sentence for absence without leave, repeated escape, burglary, auto theft, and rape. He was diagnosed as a psychopathic personality, emotional instability. His intelligence test showed an IQ of 92.

The inmate never knew his father well; his parents were divorced when he was 2 years old. He had a few uncles but he did not feel strongly about them except in a negative way. His mother married again, but his stepfather beat and cursed him. When he was 10 his mother died and from that time his aunts and grandmothers took care of him by turns. He had a brother and a sister with whom he got along well, but they were separated after the death of their mother.

The inmate was a nervous child. He was a feeding problem and had nightmares. He also had trouble in school.

As an adult he stole gasoline. He later worked hard in the laundry business but was mulcted of his commission. Because he was disgruntled he did considerable drinking.

He presumably got along well in the Army until he was mishandled by an officer. He went AWOL and then began a series of escapades consisting of escapes, car stealing, opportunity money and alleged rape.

According to his psychiatric evaluation he was suspicious, distrustful, hostile. He made no identification with a paternal symbol and had much depression and anxiety in confinement.

Case No. 12. A 32 year old, white, former private was sentenced for ten years for desertion. He later received clemency of five years. The Shipley-Hartford scores were VA 15.1, AA 11.0, MA 10.7, CQ 72. His diagnosis was that of psychopathic personality, emotional instability, chronic alcoholism.

His father was a lead and zinc miner who died of tuberculosis when the inmate was 7. His mother married again, but his relations with his stepfather were not congenial. His mother had generally poor health, but she took care of the home as much as she was able. He was the only boy, with 1 older and 1 younger sister.

As a child he was unhappy and seclusive. Later he became wild and irresponsible, and engaged in petty thievery.

As an adult he did solitary drinking and was often absent from work. He hoboed and hitchhiked about the country, breaking and entering houses. He was married and then divorced.

The inmate was a Selective Service delinquent. His mother said he was a coward and fearful of combat. His offenses of AWOL were due to drinking.

He was psychiatrically evaluated as having inadequate opportunity to work out a relationship with his father, and he lacked gratification from his mother. He made no identification with his stepfather.

Case No. 13. A 23 year old, white, former private received a sentence of five years for stealing money and forging a pass. He was diagnosed as a psychopathic personality with asocial trends. His intelligence score showed an AGCT of III, 101.

His father was a severe disciplinarian who had a rejecting attitude. His mother was rather rejecting too, especially when he received his sentence. The inmate was the sixth of 8 children. His 6 brothers were noncommissioned officers in his same outfit.

As a child he was reared in a congested, poor neighborhood. He always felt inferior to the others in his family. He stole and was deceitful, and was a problem at school. As an adolescent he was guilty of juvenile offenses, and in the Army he was a defiant, sneaky person, disliked by the other men. He was evaluated psychiatrically as a "stool pigeon type." He did sneaky things and did not hesitate to involve others when there were advantages to him.

Case No. 14. A 35 year old, white, former private was sentenced for desertion, bigamy, forgery, and stealing a car. His diagnosis was psychopathic personality, inadequate personality. According to the Shipley-Hartford test his scores were VA 18.6, AA 17.3, MA 18.0, CQ 102.

His father was a high school teacher, the "pal" type, but strict. His mother died when he was young, and his stepmother was kindly although she blew up at the slightest infraction. She did not handle him well—she used the "silent technic." He had 1 older sister who was interested in him. No negative elements were shown.

As a child he had no early home ties. He lived with several aunts and then attended military schools. He was once in a reform school for six months. He craved affection.

As an adult he possessed some skills. He married twice and was very extravagant but had no criminal record.

He had one good hitch in the Army. He then began to drink heavily and shook off all sense of responsibility. His offenses were committed on a drunken spree.

The psychiatric evaluation showed a lack of instinctive gratification. There was no overt hostility. There were some signs of identification with a father image, a teacher in the education department.

According to the Rorschach test he was emotionally unstable, with an above normal IQ. He lacked inner control and intellectualized with tact and caution. He showed impulsivity under pressure. There were signs of deterred psychosexual development. The Bender test showed trends of compression and rigidity.

Case No. 15. A 21 year old, white, former private received a sentence of five years for absence without leave. He was diagnosed as a psychopathic personality, emotional instability. His Shipley-Hartford test score was MA 15.4.

His father was a heavy drinker, but not abusive. He was eventually sent to a sanatorium for alcoholism. His mother left her husband when the inmate was in the seventh grade. He was the youngest of 4 children.

He left school when his parents separated, and then started to smoke and drink. With others, he was in frequent trouble for juvenile offenses, and became involved in gang fights. He was sent to the CCC instead of to reform school.

As an adult he had an unstable work history. He was guilty of petty larceny. In working with his father he became a heavy drinker himself.

In the Army he did not adjust well, presumably because he wanted to go overseas. He drank considerably and had numerous short AWOL's. He was in general a rather passive person.

According to the psychiatric evaluation he had confused loyalties. He was ambivalent to his father with some element of identification in its unwholesome aspects. He expressed suicidal and guilt laden remarks.

The Rorschach test showed him as a rigid neurotic with an immature personality and pseudo-intellectual evasiveness. Under pressure there would be a burst of blind impulsivity, not destructive but childish. His stereotyped, abstract thinking was not developed. The Bender test showed emotional lability between expansiveness and constriction.

Case No. 16. A 23 year old, white, former private was sentenced for four and one-half years for larceny of a pocketbook by violence. He was diagnosed as a psychopathic personality, emotionally unstable. His AGCT score was 107 and the Shipley-Hartford scores were VA 15.9, AA 12.5, MA 14.1, CQ 78.

His father died when the inmate was 19. He was devoted to his mother, who punished him rarely but severely. She was the dominant

person in the family. The inmate was the third of 5 children, but had little in common with his siblings. He chose associations outside the home in pool halls, etc. He fussed considerably with 1 sister.

As a child he fought everybody in school, and was arrested for drinking at 14 years of age. He played hooky and was expelled when he was 16.

When he grew up he had a roving disposition, being discontented with jobs, and drinking to excess. He had a sentimental attachment to his mother. He lived with a woman for a year, but could not see marriage.

In the Army he drank considerably, and was fearful and hostile to the service.

The psychiatric evaluation made was that he fought his attachment to his mother, but never identified himself with his father. He showed no warmth to the siblings. Alcohol was a part of his escape process and partly was a symbol of his own puerile defiance.

According to the Rorschach test he was a withdrawn introvert, emotionally egocentric, living in a world of fantasy and ignoring all outer pressures. The Bender test confirmed the impression of emotional withdrawal and compression.

Case No. 17. A 28 year old, white, former private received a sentence of five years for absence without leave. He was diagnosed as a psychopathic personality, emotionally unstable. His intelligence was average.

His father was a hot-tempered artist, who was divorced from his wife from the time the inmate was 9 years old. The father took care of him part of the time, and once administered a very brutal beating. He eventually married three more times. The inmate's mother was also quick tempered. She worked and gave the inmate little care. His stepmother was rejecting. He had 1 older brother and 1 paternal halfbrother. The relations with his brother were quite good, and there was some identification.

During his childhood he was nervous, irritable and seclusive. He had little care, roaming the streets, and attending school very irregularly.

As an adult he was restless. At 19 he married a girl whom he had made pregnant. They did not get along, and he started drinking and became frequently involved in drinking episodes. He was arrested thirty to forty times in his home town.

In the Army he served one enlistment without trouble. He later

went AWOL repeatedly because of drinking. His wife had a child, the third, by another man. They were then divorced.

His psychiatric evaluation was that he was ambivalent to his father with much hostility. He had failed to make a healthy masculine identification. His resorting to alcohol, a neurotic pattern, was a defense against anxiety and depression. He was talkative and wanted help.

Case No. 18. A 24 year old, white, former private was sentenced to serve ten years for desertion. The sentence was later reduced to five years. He was diagnosed as a psychopathic personality, emotionally unstable. The Shipley-Hartford scores were VA 13.9, AA 12.0, MA 12.7, CQ 86.

His parents were divorced in 1936. His father then remarried. He was an unstable person, temperamental, hostile to the inmate persistently and blaming him unnecessarily. During his marriage he traveled extensively. He appropriated money from the inmate. The inmate's mother was an easygoing person who supported herself as a domestic worker. He was the only child.

As a child he was placed in many schools while his parents traveled. He mistreated and hated his father, and ran away from him. He became the leader of a small inferior gang of petty thieves, and later worked with his father in carnivals.

As an adult he had an unsteady work history. He married, was unhappy because his wife nagged him, but managed the family well.

His adjustment to Army life was tenuous. He reacted badly when he was not given passes to see his wife. He was given a promotion to T/5 but refused to wear the stripes. He went AWOL to watch his wife, and then went into panic when given a general court martial. He was later divorced from his wife.

His psychiatric evaluation was that he was a rather nervous, suspicious person who built up a defense against his early frustration from his father. His distrust, hostility, and denial of his father's impatience hindered any healthy masculine identification.

Case No. 19. A 24 year old, white, former private was sentenced for one year for absence without leave. His diagnosis was that of psychopathic personality, inadequate personality. The AGCT score was IV 85.

His father was a heavy drinker, separated from his wife. The inmate lived with his father part of the time in a rural environment. His mother's personality was not showed. She cared for her other

children but allowed the inmate to go live with his drunken father. The inmate was the youngest of a family of 6.

He was a nervous child who walked in his sleep. He was enuretic all through childhood and adolescence. He had a poor school record, reaching fifth grade and repeating almost every one. He wanted to get out for himself.

As an adult he worked at various jobs, farming, as a mill hand, etc. He developed a pattern for heavy drinking, and had four or five arrests for drunkenness.

In the Army he still drank considerably. During his frequent AWOL's he headed for home under the influence of liquor. He married a widow with whom he had lived for a while.

According to the psychiatric evaluation he was a very shy, withdrawn, insecure individual. He was dependent upon a mother person and could not cope with situations on a mature adult level. He made a spurious identification with his father.

Case No. 20. A 29 year old, white, former private was sentenced to serve five years for absence without leave. His diagnosis was that of chronic alcoholism and emotional instability. His intelligence was superior.

His father was a hard-working man who spent little time with his children. His mother was a good woman who worked hard with her large family. He had 3 older brothers, 2 older sisters, and 2 younger brothers. The sibling ties were loose.

During his childhood he associated with rough kids, and was arrested for stealing at 12 years of age. He was truant from school and ran away from home two or three times when he was 15.

As an adult he acquired drinking habits early—he wanted to keep up with the group. His employment record was poor. He married, but the relations were strained because of his drinking. He was arrested many times for offenses growing out of his drinking. He made attempts at suicide.

In the Army his repeated AWOL offenses were due to his drinking.

In the psychiatric evaluation he was found to have had a distant relationship with his father, but he had sentimental attachments to his mother. He was irresponsible in marriage, but reacted severely to divorce—suicide attempts and later a determination to quit drinking.

The Rorschach test showed his emotional instability. He was withdrawn, basically introverted but egocentric. He was emotionally immature, aggressive under pressure and showed psychotic retreat trends. The Bender test confirmed his emotional instability. It dis-

closed distorted conceptual thinking, with disoriented and perseverant content.

Case No. 21. A 24 year old, white, former private received a five-year sentence for desertion. He was diagnosed as a psychopathic personality with asocial trends. He had an IQ of 79.

His father was a man in poor health, having stomach trouble. He was a member of the Holy Roller faith. The inmate's mother died when he was 4 years of age. His stepmother mistreated him.

As a child he was in an orphanage until he was 9 years old, and later ran away from home continually.

After he grew up he did considerable drinking, hitchhiking and hoboing. He was arrested for stealing, forgery, shoplifting, home-breaking.

He made a poor adjustment to Army life. He went off on drinking AWOL's and finally deserted because he did not like the first sergeant. He was a wolf in confinement (aggressive homosexual).

The psychiatric evaluation was that he had always been suspicious, feeling disliked by everyone. His behavior was semi-suicidal and pleasure-seeking. He made no identification with his father and there was a dearth of maternal affection.

Case No. 22. A 30 year old, white, former private was sentenced to serve three years for absence without leave. He was diagnosed as a psychopathic personality, with asocial trends. His AGCT score was III 100 and the Shipley-Hartford score was MA 115.

His parents were divorced when the inmate was 12. Although his father had been allegedly close to him before that, after divorce he paid no attention to the inmate and showed no interest when he was in trouble. His mother was always overprotective, but in late years had no patience with him. He had younger brothers and had been somewhat disdainful of them, but was ashamed to face them because they had served honorably.

The inmate was an inconsiderate child. At the age of 12 he started to steal cars.

As an adult, car theft was chronic. He showed recidivist tendencies and was confined to reformatories.

In the Army he was unhappy because of frequent allusions to being an exconvict. In confinement he escaped to get liquor and hid a package of benzedrine.

According to the psychiatric evaluation he made no masculine identification and had little concern for the welfare of people. He

was a smooth, quiet person who behaved very well, but resorted to sneaky performance.

Case No. 23. A 23 year old, white, former private received a sentence for stealing a wrist watch and $57.00 from a soldier (AW 93) He was diagnosed as a psychopathic personality, inadequate personality. His AGCT score was IV 78, VA 11.5, AA 9.4, MA 9.9, CQ 82.

His father had been a miner who drank excessively at one time. He had had a stroke, partially paralyzing his limbs. His parents separated approximately six years before his confinement, and he was supposed to have missed his father very much after the separation. He was presumably very close to his father. His mother had nervous spells and there were many arguments in the family. The inmate was the second of 6 children.

He had convulsions at the age of 3, and complained of abdominal pains from the age of 10 until he was 17, which may have been constipation. He quit school to work with his father in coal mines.

As an adult he held many jobs. Drinking was never a problem for him; he drank only socially. He married but always felt closer to his mother than his wife.

He did not want to go into the Army. He drank little, but stole a watch and a wallet when he had the chance. He was restored to duty and then went AWOL.

According to his psychiatric evaluation he was insecure, inadequate, defendant. He had made a pseudo-identification with his father. There were also unresolved maternal ties and definite signs of schizophrenia.

The Rorschach test showed schizoid, confused thought processes. He had psychotic fantasies, paranoid trends and perseveration. The Bender test revealed emotional compression and a mild distortion.

Case No. 24. A 20 year old, white, former private was sentenced for five years for desertion. He was a psychopathic personality, inadequate personality. His AGCT score was III 94, the Shipley-Hartford scores were VA 17.8, AA 16.5, MA 17.5.

His father was alcoholic, although not abusive. His mother was domineering and strict. She beat the inmate with whips and straps for his inadequacies. He was the third of 6 children.

As a child he was rather seclusive, enjoying solitude. He built a tree home in his yard. He truanted from school in later years and finally took a truck and went for a joy ride.

When he grew up he did not care for girls. He objected to his mother's beatings and ran away frequently by hopping trucks, but he always came home after a while.

He never adjusted himself to Army life. When he heard a truck on the road he was off.

His psychiatric evaluation was that he felt rejected by his mother. He had an ambivalent attitude toward his father, with whom he felt sympathetic, but he had no true identification with him.

According to the Rorschach test he had an inadequate personality with no mature inner control and creativity. His inner drive was based on animal impulsiveness with associated signs of anxiety. He lacked emotional maturity to meet the pressures to which he was very sensitive. His attempts at withdrawal were unsuccessful because his poor intelligence could not build up defenses. He was also immature in sexual development. The Bender test proved that he was emotionally compressed. He had a co-arctated personality, with some emotional lability.

Case No. 25. A 20 year old, white, former private was sentenced to five years for desertion. He was diagnosed as a psychopathic personality, emotionally unstable. His AGCT score was only IV 86, but the Shipley-Hartford scores were VA 14.7, AA 14.9, MA 15.1, CQ 99.

His father was an alcoholic, and poverty stricken. He was literate only in Spanish. He had no police record. His control over the inmate was poor. His mother was an easygoing person suffering from tuberculosis. He was the sixth of 7 children. His brothers drank considerably and there was some friction between the siblings.

When he was a child he was willful, inconsiderate, nervous and impatient.

When he grew up he had a forced marriage and wanted a divorce at the time of his confinement. He drank considerably and smoked marijuana.

In the Army he made no attempt to support his wife. He went AWOL more than once, deserted, and escaped confinement.

His psychiatric evaluation was that he was hostile to authority and to his father for having set such a poor example. He was an aggressive adolescent who was not ready to assume adult obligations.

According to the Rorschach test he was extremely immature and had childish oppositional tendencies, with uncontrolled basic animal drives. He approached environmental pressures impulsively and sensuously and his tendency was to retreat when the environment

pressed too severely. His sex attitude seemed grossly sensuous and impulsive in nature. The Bender test showed him to be emotionally expansive and impulsive.

Case No. 26. A 21 year old, white, former private was sentenced to serve five years for absence without leave. He was diagnosed as a psychopathic personality, emotionally unstable. The AGCT test showed a score of IV 85. The Shipley-Hartford scores were VA 13.9, AA 12.0, MA 12.7, CQ 85.

His parents were allegedly separated, and his father was a chronic alcoholic. His mother was "no good" and a trouble maker. She was a strict Catholic who lived in common law with another man for fourteen years. There were 6 children by common law, 4 by the real father. The relationship among the children was poor.

When he was a child the inmate stayed away from home a good deal, staying in all-night movies. Stealing finally took him to a reform school.

As an adult he was arrested for unlawful assembly. He escaped and is still wanted by the police. He drank excessively and used marijuana. In all, he had ten arrests.

In the Army he drank too much and had several AWOL's.

According to his psychiatric evaluation he lacked a paternal symbol. He felt severely rejected by his mother and had no sense of values, nor did he have any frame of reference.

The Rorschach test showed him to be an inadequate personality, with strong sexual perversion, possibly homosexuality. He had infantile emotional urges and poor emotional control of basic drives. There were egocentric introverted motivations without much anxiety. The Bender test showed emotional compression and withdrawal trends. He evidenced signs of immature regression in thought content and processes but not to a psychotic degree.

Case No. 27. A 25 year old, white, former private received a sentence of five years of absence without leave and escape. He was diagnosed as a psychopathic personality, emotionally unstable. His Shipley-Hartford scores were VA 11.9, AA 10.5, MA 10.7, CQ 87.

His father was asthmatic. He was never with the inmate very much. His mother, who had some Indian blood, died of pneumonia when the inmate was 10 years of age. He had 2 older brothers and 1 older sister, 1 younger brother and 2 younger sisters.

As a child he lived in an orphanage from the age of 10 until he

was 17, except for short-time placements in foster homes. He was sullen and dishonest and adjusted poorly. He deserted the CCC.

When he grew up he was ruthless and high-tempered. He was not dependable, would not work, and did some drinking.

In the Army he had several AWOL offenses.

He was psychiatrically evaluated as lacking an adequate paternal symbol. The loss of his mother affected his personality also. He was aggressive and had unsocial attitudes.

According to the Rorschach test he was "protoplasm." He was immature, motivated by infantile, uncontrolled drives, but was withdrawn, evasive, with some anxiety. He showed some compulsiveness, with poor abstract thinking. The Bender test demonstrated emotional compression with decreased intellectual functioning.

Case No. 28. A 28 year old, white, former private received an original sentence of eighteen months for absence without leave and desertion, and then received an additional five years for escape and desertion. His Shipley-Hartford scores were VA 14.7, AA 10.5, MA 11.9, CQ 70. His diagnosis was that of a psychopathic personality, emotionally unstable, addicted to marijuana and barbiturates.

His father deserted the family when the inmate was only an infant. His mother was in poor physical health. She was dependent on her own mother for support, although she was able to do some work. The inmate was the only child.

He was unhappy when he was a boy. His mother gave him no supervision and indulged him. He ran away from home at 16, and was generally wild and irresponsible.

As an adult he was sentimental, moody, and impulsive. He gambled profusely and professionally. He was addicted to all types of drugs periodically, but was not strongly addicted to any one. He was nomadic and had many arrests for minor offenses. He married.

In the Army he made a very poor adjustment. He committed offenses to see his wife and to obtain drugs. He also made two abortive suicide attempts.

According to his psychiatric evaluation there was an absence of any family frame of reference. There was no father symbol and inadequate maternal care and discipline.

Case No. 29. A 27 year old, white, former private received a ten-year sentence for desertion and attempted escape. The diagnosis was psychopathic personality, inadequate personality. The Shipley-Hartford scores were VA 13.1, AA 10.5, MA 11.2, CQ 79, IQ 80.

His father and mother were living and in fairly good health. Their personalities were not shown. He had 1 older brother and 1 older sister, 4 younger brothers and 4 younger sisters. Three brothers served in the United States Marines.

He was nervous and quick-tempered as a boy, with little interest in school. He was arrested for petty theft twice, but was released with reprimand.

When he grew up he had occasional "blackout" spells. He felt intolerant of crowds and noises, shy, sensitive, seclusive, and moody. He had 2 children by a common law wife. He was divorced, remarried, and then bigamously married.

In the Army he had numerous physical complaints, and claimed that he had not received adequate medical attention. He repeatedly went AWOL.

The psychiatric evaluation showed him to be a thoroughly inadequate, inactive person, but there were no clear indications of disturbed parental attitudes. He probably got lost in the shuffle in a large family when the other children were more capable. He then sought affection in neurotic marital relations.

The evidence of the Rorschach test was that of an immature, inadequate personality, with signs of psychotic deterioration and complete withdrawal. His thinking was rigid, compulsive, automatic, and stereotyped. He was slightly deteriorated, paranoid, although he had "the mask of sanity." The Bender test showed feelings of insecurity and a compulsiveness to maintain orientation. He had a dullness of affect although he was labile.

Case No. 30. A 37 year old, white, former private was sentenced to serve ten years for a desertion of three and a half months. He later received a clemency of 5 years. He was diagnosed as a psychopathic personality, with chronic alcoholism. His intelligence scores were IQ 112, VA 15.1, AA 12.0, MA 13.3, CQ 78.

His father died in 1929 of pneumonia. His mother was a nervous person in poor health. He had an older sister and an older brother and 2 younger brothers, one of whom had stomach trouble and one who died of stomach ulcers.

The inmate was presumably a happy child, although he was nervous and bit his fingernails. He did not apply himself at school and was expelled two times.

As a man he received a head injury in 1931, which was followed by severe headaches. He was impulsive and changed jobs frequently due to nervousness. He was arrested for fraudulent checks, as a

"sleeper", and on suspicion. He married and was divorced. He then drank and was generally irresponsible. Later he remarried.

In the Army he had had one previous AWOL before sentence, and pleaded eloquently for restoration.

In his psychiatric evaluation there was no clear indication of conflict. There was, however, an absence of parental identification.

The Rorschach test showed him to be emotionally unstable. His motivations were uncontrolled drives; he responded aggressively with blind impulsivity, neurotic shock, some depressive anxiety. He rationalized with no insight. The Bender test gave evidence of emotional lability, wild thoughts, distortions, and immature regressions.

Case No. 31. A 21 year old, white, former private received a sentence of five years for desertion. He was diagnosed as a psychopathic personality, with emotional instability and chronic alcoholism. His IQ was 105 and his other scores were VA 12.3, AA 13.0, MA 12.7, CQ 104.

His parents were separated when the inmate was 2 years old, and then divorced. His mother was probably a peculiar individual. She worked and the maternal grandmother cared for the boy from the age of 2 until he was 7. Neither the grandmother's nor the grandfather's personalities were shown. The inmate had 1 older sister and 2 younger ones. They were all cared for in the same way as the inmate.

As a boy he showed some nervousness, but took responsibility very early. He quit school to help the financial stress. He always was involved in fights because of his temper.

As a man he acquired drinking habits early.

In the Army he had several AWOL's, made a hasty marriage, and continued his drinking.

Case No. 32. A 20 year old, white, former private was sentenced for five years for desertion. He was diagnosed as a psychopathic personality, emotionally unstable. According to the Shipley-Hartford test his MA score was 12.3.

His father died when the inmate was a baby. His mother claimed that he was illegitimately born. He had 3 or 4 rejecting stepfathers. His mother was a "hard" person, who drank and caroused but was protective toward the inmate. There were no other children.

As a child he did much shifting about. He stole and was often truant. He was placed in a foster home for a while, but that failed.

He went into the Army at an early age with no adult criminal

record. He failed to comply with Army regulations, however, and associated with older and undesirable enlisted men.

According to his psychiatric evaluation he was suspicious and distrustful. He had made no adequate male identification. His feeling was defiant towards his mother and he disapproved of her actions.

Case No. 33. A 20 year old, white, former private received a sentence of four years for absence without leave and car theft. His diagnosis was that of psychopathic personality, emotional instability. His Shipley-Hartford score was MA 15.1.

His father was a sullen, indolent, quarrelsome man, and he was in contact with the inmate for only the first one and one-half years. His mother was an exhibitionistic, selfish, and rejecting woman. She, too, was in contact with him only the first one and one-half years. His main parent was his grandmother, who was sexually promiscuous and who gave him no discipline. He was the second of 3 sons. There is no information concerning their relationship.

As a boy he fought and stole and was frequently truant. Once he broke into a school building and shot a boy.

He joined the Army at the age of 18 years. He had no FBI record. He seemed restless, disgruntled, and hostile because of not getting an assignment to his liking. He was angered because of "false" accusations of theft.

According to his psychiatric evaluation, he had made no male identification and was suspicious and surly. He expressed no family loyalties.

The Rorschach test showed that he was basically introverted and somewhat egocentric. A fantasy life showed strong trends towards introversive psychotic retreat. The test showed in his make-up morbidity, destructiveness, hostile aggressive attitudes. His personality was on the verge of psychotic breakdown. There was emotional disturbance in some sexual symbolism. The Bender test evidenced severe constriction of emotional reaction.

Case No. 34. A 34 year old, white, former private was sentenced to serve two years for absence without leave. He was a psychopathic person, emotionally unstable. The intelligence scores were not shown.

His father died in 1926 while the family lived in Eire (Ireland). He was said to have been a pastor and an illiterate Irishman of personality not described. His mother was a volatile person, going rapidly from laughter to tears, to rages, being very nervous and high strung.

The inmate was the second oldest of 7 children, 4 girls and 3 boys. Their relationship was not showed.

In his childhood the inmate was nervous; he bit his fingernails and had nightmares. His bad temper got him into fights.

As an adult he turned to drinking alcohol at 21, which led to several arrests. He never married.

In the Army he hated to do things that did not seem right, and he frequently lost his temper. His repeated AWOL's were associated with drinking.

According to his psychiatric evaluation he was unable to tolerate authority, especially if it seemed the least unreasonable. He flared up whenever frustrated and had no desire to change.

Case No. 35. A 25 year old, white, former private received a sentence of four years for absence without leave. His AGCT score was 98. His diagnosis was that of psychopathic personality, emotional instability.

His parents were divorced when the inmate was 6 years old, and he had little contact with his father from that time. His mother never remarried but worked. Her personality was not showed. His grandmother was responsible for his care. There was 1 other child in the family, who died in 1922.

As a child the inmate was nervous and sickly. He was guilty of some petty thievery.

When he grew up he engaged in gambling and betting. He had had some trouble with the police for drinking; he had also tried narcotics and was sexually promiscuous.

He had a lack of responsibility towards the Army, and had no feeling of duty.

According to his psychiatric evaluation he was indifferent to constituted authority with little depth of feeling for social demands.

Case No. 36. A 24 year old, white, former private was serving a sentence of eight years for desertion. He was diagnosed as a psychopathic personality, inadequate personality. His intelligence scores show an AGCT score of II 116; Shipley-Hartford scores were VA 15.9, AA 12.5, MA 14.1, CQ 78.

His father was a coal miner who drank heavily at one time. His back bothered him, but he was an easy going, talkative person. The family moved about a good deal. His mother was a nervous person in poor health, who worried excessively. He had 3 younger sisters, but he did not get along well with them.

The inmate was a nervous, shy boy who bit his fingernails and had enuresis until 15. He was treated by "nerve tonic" and finally quit school because of nervousness. He had seizures "like epilepsy" following a fall.

As an adult he ran away from home "on a trip." He started drinking at the age of 18 and married at 19. He was presumably a good, reliable worker who had 2 children. He once was arrested for fighting with his sister. He depended on his father to make his decisions for him; consequently, he was slow in making up his mind.

In the Army drinking was the cause of his trouble. He joined the Army at an early age and deserted the peacetime Army for nearly four years. He was later restored to duty and deserted again, presumably to help his family.

His psychiatric evaluation evidenced that he had made a fair surface adjustment but was essentially insecure and superficial. He had failed to attain a normal masculine level. He escaped his responsibilities by resorting to alcohol.

Case No. 37. A 28 year old, white, former private received a sentence of five years for escape and absence without leave. He was diagnosed as a psychopathic personality, emotionally unstable. His Shipley-Hartford scores were VA 16.2, AA 13.0, MA 14.7, CQ 79.

His father was a poor machinist and his mother was an invalid with partial paralysis from a broken neck. He had 1 older brother who drank heavily and another brother who was all right.

During his childhood he was stubborn, resented discipline, and wanted to do as he pleased. He went to the CCC at 17, and from that time on he was on his own. He received an honorable discharge from the CCC, but he re-entered and received a dishonorable discharge for breaking rules.

As an adult he drank excessively from the age of 17. He traveled about, doing some hoboing. He was guilty of auto larceny and had several small arrests, but spent two years in the penitentiary for a second charge of larceny. He was released from there to join the Army. On one of his many drinking bouts he married a barmaid.

In the Army his dislike for discipline or regimentation prevented his adjustment. He went on repeated AWOL's in a concerted plan to get out of the Army. He did well in confinement.

According to his psychiatric evaluation he was self centered, self satisfied, unscrupulous. He believed everyone in the world was insincere. He was suspicious and hostile but served his time well in order to gain his release. He feared, hated, and flaunted authority, but a

clear picture of interpersonal relations is not shown. He showed a reaction to poverty and his mother's invalidism.

Case No. 38. A 22 year old, white, former private was serving a sentence for absence without leave and for forging and passing bad checks. He was diagnosed as a psychopathic personality, emotionally unstable. His Shipley-Hartford scores were VA 13.5, AA 13.0, MA 13.3, CQ 96.

His parents were separated periodically. His father had been crippled for fifteen years. His mother had a rejecting attitude through most of his childhood. He said that "he never knew the love of a mother." He was the youngest of 7 children, all boys. The inmate felt that he was disliked by his brothers. They all served in the armed forces.

As a boy he was unhappy because of the frequent separations of his parents. He was an aggressive boy, who was brought to juvenile court for living on the streets. He was later picked up for petty theft and vagrancy.

When he grew up he married and had 1 child. There was much friction between him and his wife because of her infidelity.

In the Army he had had one previous AWOL before his sentence, due to trouble between his mother and his wife. He showed a lack of application to military duties because of concern over domestic matters.

A psychiatric evaluation of this man evidenced an overt rejective, inadequate, fraternal symbol and reaction by aggression. His search for affection was not adequately gratified, so his unsocial pattern did not seem too unreasonable.

According to the Rorschach test he was unstable and withdrawn, with a "warring" of inner drives. He was aggressive and impulsive and used neurotic mechanisms. There was a lack of identification. The Bender test showed him emotionally flattened. There was perseveration and regression of that process.

Case No. 39. A 27 year old, white, former private received a sentence of five years for desertion. The diagnosis of psychopathic personality, emotional instability, chronic alcoholism was made. His Shipley-Hartford intelligence scores were VA 16.6, AA 14.2, MA 15.7, CQ 85.

His father was a heavily alcoholic man who died in 1933 from drowning. His mother was a nervous, hard-working person. The inmate was the oldest in a family of 9 children.

As a child he was nervous and afraid of his father when he was drinking. It is possible that chorea was present. He was often truant and started stealing at the age of 11 or 12.

As a man he had a shifting work history. He never married. He started drinking socially, but later became a spree drinker. He was shy of people. He had twenty-four arrests for drunkenness.

Most of his Army career was spent in the guardhouse, due to AWOL's and offenses as a result of his drinking.

He was psychiatrically evaluated as being insecure, anxiety ridden, with spurious identification with a father whom he feared and probably hated.

The Rorschach test showed him as an egocentrically withdrawn person. He had an inadequate impulsiveness when forced without way of retreat to face the world, but he avoided all contact with outer pressures whenever possible. The Bender test gave evidence of lability. There was more emphasis on expansive reaction than on compressive withdrawal.

Case No. 40. A 25 year old, white, former private, was serving a sentence of five years for absence without leave and for fighting with an officer. His diagnosis was that of psychopathic personality, asocial trends. The Shipley-Hartford scores were VA 15.1, AA 12.5, MA 13.7, CQ 81.

He never saw his father—he left before the inmate's birth. He had a stepfather who was a hard worker but had little contact with the inmate. His mother remarried when he was 4. She, too, had little contact with him. His main parent was his 97 year old, widowed grandmother. He was the only child in the household, so his grandmother took him with her when she went out to work. He had 7 half-siblings, but he had little contact with them.

In his childhood he showed restless, nomadic tendencies. He hopped freight trains, forged checks, and finally found himself in reform school. He had a dishonorable discharge and was discharged from the CCC for a shooting fray.

As an adult he did much shifting about, shacking up for his keep. He was guilty of repeated offenses for vagrancy, drunkenness, fighting, burglary, the use of marijuana and alcohol to excess.

He became tired of the Army, so he got drunk and went home. He went AWOL after a fight with a lieutenant.

According to his psychiatric evaluation, he had no family ties. There was an absence of a paternal symbol. He had disrespect for

the rights and property of others, especially under the influence of alcohol.

The Rorschach test showed him to be immature, emotionally unstable, and dull intellectually. His uncontrolled, infantile motivation was toward withdrawal, but under pressure he was impulsive, destructive, and grossly sensual. He was capable of only poor abstract thinking. The evidence of the Bender test was that of volatile, emotional reactions. He was rigid and perseverating.

Case No. 41. A 23 year old, white, former private was serving a sentence of five years for absence without leave and for maiming himself to avoid duty. He was diagnosed as a psychopathic personality, inadequate personality. His AGCT score was IV 83.

His parents were divorced when the inmate was 2 or 3 years old. He had no knowledge of his father—his stepfather took good care of the family. His mother remarried when he was 12. She was "the best type of woman," although she was overprotective. He was the youngest of 6 children, with whom he claimed to have had a good relationship. One of his sisters was a narcotic addict.

There is no early childhood behavior history, although he was known to be too troublesome. He was sent to a vocational institute for getting a girl pregnant.

There is a sketchy work history of him as a man. He associated with homosexuals and was under observation at mental hospitals. He was a seclusive person who used marijuana from the age of 13.

In the Army his disobedience caused him to have court martials. He did not adapt himself to military life, since he did not believe in violence. He claimed amnesia for self maiming.

The psychiatric evaluation showed him as inadequate, with a large homosexual component. He made a strong identification with his mother, but had no paternal relationship.

Case No. 42. A 20 year old, white, former private received a sentence for absence without leave. His diagnosis was that of psychopathic personality with emotional instability and alcoholism. His intelligence scores were not shown.

His father died of heart trouble when the inmate was 5 years old. His mother had borne 11 children and never remarried. She died when the inmate was 12 years old. Eight of the 11 children died or were killed at various ages. The inmate was the middle one of 3 surviving boys.

During his childhood his schooling was haphazard because he did

not maintain residence at one place very long, especially after the death of his mother. He stayed out of school to work in order to feed and dress himself. At 14 he built a still.

He started drinking heavily at the age of 16 after the death of an older sister, but had done some drinking since the age of 9; he was reared in a moonshine country. He was arrested a few times for drinking, but had no other offenses. For a while he worked in the shipyards.

After he was in the Army he still did much drinking. He had two absences without leave; he would go home to loaf and drink.

He was psychiatrically evaluated as a thoroughly depraved individual, who made his adjustments to life purely on the pleasures of dulling his senses with alcohol. He had no wholesome masculine ideal and no feeling of security with anybody.

Case No. 43. A 28 year old, white, former private was sentenced to serve five years for desertion. He was diagnosed as a psychopathic personality, inadequate personality. He had a Shipley-Hartford score of MA 14.0.

His parents had been divorced since his earliest infancy. His father was irregularly employed, and later remarried two times. He was an irresponsible man, although he did not do much drinking. He saw the inmate occasionally. The inmate had 2 stepfathers, one of whom died. The personalities of none of these men are known. His mother, grandmother, and older sister cared for the Inmate. His mother worked, and later remarried two times. He had 1 living older sister.

As a child, he remained with his grandmother until he was 5 years old. He did some nail biting, and he had a fear of the dark. At the age of 14 he was arrested for malicious mischief, and at 16 he was twice guilty of burglary, which took him to reform school.

When he grew up he worked steadily for a while. He then traveled for a time on itinerant jobs. He did no drinking. He was married twice—his first marriage ending in divorce because of his infidelity. He had 2 children with his second wife.

He claimed to have deserted the Army in order to make money for his wife. He was not always truthful in his statements.

The psychiatric evaluation showed no adequate frame of reference. He lacked an identification with a wholesome father symbol. There were no lasting libidinal attachments, and he had a tendency, without assuming adult responsibilities, to put up a false front.

Case No. 44. A 23 year old, white, former private received a

sentence of three years for escape, stealing and driving away an automobile. His diagnosis was that of psychopathic personality, inadequate personality. He had an IQ of 74.

His father was actually married to the inmate's grandmother, The inmate always considered his grandmother to be his real mother and his mother as his "sister." His father was a no-good man, now dead, who probably served time. The inmate's "sister's" husband had a poor relationship with him. The inmate was born when his real mother was 14 years old. His grandmother later died, and his "sister," as he said, overindulged him.

He was reared in an orphanage, but lived, off and on, with his "sister" and his "mother." As a child he had the wrong kind of playmates, and did not get along well in school. He was often truant, and failed two times.

As a man he was rather backward and shy. He did a little traveling about for a while, not keeping a steady job. He did some drinking, and liked to drive a car. He married at one time, but did not support his wife. He was also once investigated for auto theft.

After he went into the Army he did more drinking than before. He had several court martials for sleeping on sentry post, missing guard duty, and for the theft of a car. His actions were probably associated with frustration in not going overseas because of his poor eyes.

His psychiatric evaluation described him as a withdrawn and shy person, who tried to bolster his inadequacy with alcohol. He was overwhelmed by the complexities of life, and was unable to make any masculine identification. He was insecure and unable to withstand frustrations.

Case No. 45. A 31 year old, white, former private was sentenced to four years for absence without leave. His diagnosis was that of drug addiction and chronic alcoholism. His AGCT score was IV 26.

His father was a passive, easy-going person, who died in 1944. He had been disabled, due to a railroad injury. His mother was the dominating factor in the family. She died in 1943 of a "rare glandular disease." He had 1 younger and 1 older sister, whose relations with the inmate are not known.

As a child, the boy was perhaps overindulged because he was the only boy. He neglected school in favor of sports, and at one time wanted to be an evangelist. He left school at 14 in order to work after his father was injured.

As a man, his drinking habits were established early, at the age of 16. He was rather restless, changing jobs frequently. He had

eighteen or more arrests for drinking, trespassing, and transient vagrancy. He contracted gonorrhea, and said he would not get married.

He had belonged to the National Guard and to the Marine Corps, and had had three previous court martials for AWOL's.

He was psychiatrically evaluated as having a tendency to put on a false front of erudition. He had no satisfactory masculine symbol, and he was unable to reach a level of adult performance, so sought subterfuge.

Case No. 46. A 21 year old, white, former private was sentenced to serve five years for absence without leave and for escapes. He was diagnosed as a psychopathic personality, emotionally unstable. His intelligence scores were IQ 108, VA 15.5, AA 13.6, MA 14.7, CQ 87.

His father died when the inmate was 4 years old. His first stepfather was abusive to his mother and to the children, was a poor provider, and they were finally divorced. His second stepfather was a nice man, who had been married to his mother for only a short time when the inmate was confined. Nothing was known of his mother. He had 1 older brother and 1 younger sister.

When a boy, the inmate had had whooping cough, followed by otitis, causing a partial deafness. He had faintings, spells, and nightmares until he was 17 years old. He was never a behavior problem in school, but he quit school in the tenth grade at the age of 18.

In 1941 he was guilty of robbery by assault. He was sent to jail for vagrancy with a three day sentence because he tried to break away. He was arrested again for breaking into an ice cream parlor.

He deserted the Army, and was charged with AWOL. He impersonated a second lieutenant, and thus escaped. He was then guilty of car theft and forgery. After confinement he attempted to tunnel out, and once tried to cut the fence at Fort Missoula and was shot by a guard.

His psychiatric evaluation was that he was disinterested, hostile, aggressive, and suspicious. He lacked proper motivations and showed a paranoid attitude to society. There was a complete absence and defiance of any masculine authority.

The Rorschach test showed him to be decidedly neurotic. He was emotionally blocked, withdrawn, and tense. He was impulsive, but not hostile or destructive. The Bender test gave evidence that he was rigid, constricted, erratic, and labile.

Case No. 47. A 23 year old, white, former private was sentenced for desertion and two specified escapes. His diagnosis was that of

psychopathic personality, emotionally unstable. His AGCT scores were II 116, III 104.

There seemed to be no abnormalities indicated in his family life, except that both parents worked in a textile mill and gave very little supervision to the inmate. He had an older brother and an older sister and 1 younger brother and 2 younger sisters. Their relationships are not showed.

During his childhood the inmate was considered the "black sheep." He was aggressive and wild and associated with wild companions. He caused his parents both unhappiness and dissension. He often fought and was truant from school, and once he ran away from home. At 16 he assumed all responsibility for himself. He deserted the CCC and later was sent to reform school for larceny and disobedience.

As a man he was restless, not liking to hold a steady job. He hitchhiked and hoboed and did some panhandling. He made a hasty marriage and was then divorced. He remarried a 14 year old prostitute and was again divorced. He was arrested for loitering, for carrying concealed weapons, and for nonsupport.

In the Army he went on repeated AWOL's because he was dissatisfied with his outfit. He wanted to go overseas, and when he did not receive overseas orders he deserted.

His psychiatric evaluation described him as a wild, irresponsible person with no family ties. There was an absence of identification with a father figure and no sense of importance of human relationships. He had an individualistic, hedonistic ego.

Case No. 48. A 21 year old, white, former private was sentenced for wilful disobedience. His diagnosis was that of psychopathic personality, inadequate personality. His AGCT score was IV 79, and the Shipley-Hartford scores were VA 13.9, AA 9.9, MA 11.2, CQ 71.

His father was a Mexican farmer, a quiet, peaceful, hard-working man. He was a World War I veteran who did not associate with other Mexicans. He died in 1939 of stomach ulcers. His mother was a quiet person who died in 1944. He had 3 sisters and 2 brothers.

He was a rather shy and timid child, who reached only the sixth grade. There was no delinquency.

When he grew up he lived on a farm with an older brother. He had no civilian court record, but he started drinking and using marijuana after his father died.

In the Army he had 3 special court martials for AWOL's, but escaped confinement. He was suspicious, and felt discriminated against, and after marijuana he became irritable.

According to the psychiatric evaluation he was a very inadequate

individual who made a poor adjustment following his father's death. He never identified himself with his paternal figure. He resorted to escape.

The Rorschach test showed him as an immature personality with a main attitude of opposition. He had a mass impulsivity and rejected environmental pressures. He had a gross sensuality approach, but it might have been a withdrawn technic. There was no constructed inner life as control over his basic drives. He was at a dull, normal level intellectually. The Bender test showed infantile perversity and emotional lability processes rather than psychotic breakdown.

Case No. 49. A 31 year old, Negro, former private was serving a sentence for disobeying an officer, using insulting language to a noncommissioned officer, and for absence without leave in two instances. He was diagnosed as a psychopathic personality, with asocial trends. His intelligence scores were superior; the Shipley-Hartford figures were VA 17.4, AA 11.5, MA 14.1, CQ 66.

His father died during the inmate's infancy. His stepfather was good to him, but was a poor disciplinarian. He worked out of town, and so had little contact with the inmate. There was no information regarding the mother. The inmate had 1 older brother and 1 older sister. He also had 1 younger brother, who was heavily alcoholic and mentally unbalanced.

The inmate was a hotheaded youngster, restless and impulsive. He was sent to a correctional school for truancy, where he fought the principal and stole.

When he grew up he left home at 16 and boarded out. He was inclined to be argumentative. He was apprehended for stealing, and he served one year for larceny.

After being in the Army he rode the sick book, having many somatic complaints. He was also very irritable.

According to the psychiatric evaluation, he had a defiant attitude to authority. He escaped into hypochondria when trapped. He relinquished symptoms when in confinement in order to gain restoration.

Case No. 50. A 21 year old, white, former private received a sentence of five years for desertion. He was diagnosed as a psychopathic personality, inadequate personality. His AGCT intelligence score was III 95.

The inmate's father was a part Portuguese born in Hawaii, and a veteran of World War I. He was a no-good person, drinking heavily and abusing his wife. He was also promiscuous and stern and

demanding. He was, in general, inconsiderate of his family. The inmate's mother was a fine type of person, also born in Hawaii. She was kind and considerate and worried about her family. She left her husband in Honolulu and brought the children to San Francisco. There were 7 siblings, the inmate being the third of 8. They were all girls except for him and 1 younger brother.

He was in poor health as a child, overprotected by his mother. He was extremely nervous, hyperactive, asthmatic, shy. He stuttered and had night terrors. At 15 he perpetrated a burglary and ran away from home several times. He was sent to the United States by his mother in the hope that his behavior would improve.

Here he was picked up for vagrancy. He later joined the Marines, but was released after six weeks. He traveled more and then forged the names of his parents to enlist in the Army.

He had no particular trouble in his outfit, but when his mother and the other children came to this country he deserted and remained with them, fearful of returning. He escaped time from rehabilitation center.

According to the psychiatric evaluation, he had a submissive attitude to his father, but had no identification. His deep concern over his mother militated against acceptance of his own responsibilities.

The Rorschach test showed him to be neurotic, with a compulsive, rigid personality. He had no control over his basic drives, and was sensitive to environmental pressures. He lived a neurotic, introvertive retreat. His thought content was stereotyped. The Bender test evidenced a compulsive and compressed reaction and an emotional flattening trend.

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A CASE HISTORY OF PSEUDO-DEMENTIA*

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The simulation of a psychosis for secondary gains has often led to controversial psychiatric evaluation. The Russian psychiatrist, Ossipov, feels that such patients are psychopaths, unstable persons, who merely accentuate their latent tendencies by imitating the psychosis. Henderson and Gillespie discuss the occurrence of pseudo-dementia and the Ganser syndrome of approximate answers as hysterical manifestations which are quite difficult to differentiate from simulated mental disorders.

The following case is presented as evidence that there is no sharp delineation between malingering and hysteria, and that conscious and unconscious forces are in constant interaction to form the clinical picture of pseudo-dementia.

CASE HISTORY

A 26 year old private of Mexican parents was admitted to the station hospital on April 6, 1944, for psychiatric observation. He had been absent without leave for sixteen days, and had been detected a short distance from the Mexican border. Forged furlough papers were found in his possession, and under the custody of armed guards, he was returned to the guardhouse at his original base. Upon his arrival, he became sullen, depressed, refused food, and was admitted to the psychiatric ward.

When first seen, the soldier was unshaven, unkempt, appeared dejected, and stared at the floor. Direct questioning was futile as he would slowly lift his head, look pathetically at the medical officer, and mumble, "I don't know." Physical examination was essentially normal and he was placed in a detention cell. He refused all food, and remained on his bed, blankly staring at the ceiling.

Friday, Apr. 7, 1944. His condition remained the same. He was passively led into the physician's office, but remained immobile, showed no spontaneity, and bluntly answered questions with a barely audible mumble. The neurologic examination was repeated, and when pricked with a sharp pin, he said, "Finger touch me." This response was given when the pin was applied to all portions of his

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body. A match was held close to his palm and he uttered, "Feel nothing."

The interview follows:

(Date?) "Tuesday, March 1943."
(Name?) "I don't know."
(Place?) "I don't know."
(8 plus 13?) "20".
(12 plus 14?) "24".
(7 plus 9?) "12".
(6 plus 8?) "12".
(7 plus 9?) "14".
(7 plus 7?) "21".
(6 plus 6?) "18".
(2 times 3?) "9".
(4 times 3?) "21".
(Pennies in a quarter?) "13".
(Nickels in a quarter?) "4".
(Dimes in a half-dollar?) "6".
(Half-dollars in a dollar?) "1".
(Date?) "Sunday, May 1942".
(How long have you been here?) "I don't know".
(How many wheels on an auto?) "2".
(How many legs does a horse have?) "3".
(How many stripes does a sergeant have?) "None". (This answer was given in a loud defiant tone.)
(How many bars does a captain have?) "1".
(How many eyes does a dog have?) "3".
(How many tails does a cat have?) "3".
He was given a door key to hold, and said, "I don't feel it."
(What is it?) "I don't know".

When ordered to use the key on the door, he feebly fumbled about the door and placed the back of the key to the keyhole. He was led back to his room, and passively falling over his bed, he vacantly stared at the ceiling.

Saturday, Apr. 8, 1944. When urged by the ward attendant, he slowly dragged himself to the lavatory and attended to his toilet. He had been eating very sparingly and had been uncommunicative. He was very lethargic and emotionally blunted. When taken to the physician's office, the patient walked very slowly, and paused after each step. He sat down and stared at his hands.

(How do you feel?) "I don't know".
(Why are you here?) "I don't know".
(Are you a prisoner?) "I don't know. Let's go for a walk."
(What would you like to do?) "Nothing".
(Rather stay in your room?) "Like to go to a show".
(May a prisoner go to a show?) "I'm not a prisoner".
(Why are you here?) "I don't know".
He was then given various objects to identify.

Object	*Response*
matches	"Fire"
snapshot	"Camera"
nickel	"Quarter"
dime	"Nickel"
watch	"Clock"
pen	"Pencil"
eye	"Nose"
lips	"Tongue"
tie	"Shirt"
shirt	"Coat"
desk	"Table"

Easter Sunday, Apr. 9, 1944. The patient urinated in bed although there was a urinal in his room. In the morning he bathed himself, but his answers to all questions were, "I don't know." He possessed a peculiar blank expression, stared into space, and revealed mild catatonic features. Although remaining in bed all morning, he did read the magazines that had been left in his room. In the afternoon, the rain came down in torrents, and the patient innocently stared at the physician and mumbled, "Come out and play baseball."

Once again he was given a sensory test which revealed a complete bilateral corneal anesthesia. He was shown a lighted match, and promptly extinguished the flame by crushing it between his fingers. When given a book of matches, the patient casually lighted one match and blandly held the ignited match in the palm of his left hand until the physician extinguished the flame.

(Feel the heat?) "No".

(Did it pain?) "I don't know".

He refused to answer further questions and was led back to his room. Under careful observation, he spent the entire evening star-

ing at the ceiling, but occasionally turned on his side to read a magazine.

Monday, Apr. 10, 1944. His condition remained unchanged, and he was given 7½ grains of sodium amytal, intravenously. He offered no resistance to the treatment. At the conclusion of the injection, he became very alert, irritable, and shouted,

"I know what I'm doing. I know my points. Leave me alone. I will get that guard. I'll murder him."

(Who?) "That damn guard who yelled at me in the guardhouse."

(Why were you absent without leave?) "I was going to California to look for my two children. That's all. I asked for a pass and they wouldn't give it to me. So I went. I was going to come back. They caught me in Texas. I wasn't going to Mexico. Sure I was coming back."

(Why have you been acting so peculiarly lately?) "I don't know. I was mixed up. I don't know."

(Would you care to shave?) "All right. I will take a shave tomorrow. I feel better now."

He was placed on his bed at 11 a. m. and slept soundly until 3 p. m. Upon awaking, he exhibited the same vacant apathetic facies and gave the stereotyped reply, "I don't know," to all questions. He was told that all further interviews were to be discontinued, and that he could remain in his room indefinitely, until he was prepared to talk and act sensibly. He was urged to cooperate and warned that his attempts to cheat justice would be of no avail.

Tuesday, Apr. 11, 1944. The soldier remained in bed all day, arising solely to attend to his toilet or to nibble at his food. He appeared to be in a semistuporous state and seldom moved an extremity. His face was void of any emotion and he constantly stared at the ceiling. At 5 p. m., the physician entered the room and asked the patient if he felt any better. The soldier, without changing his position, mumbled, "I don't know." The interview stopped at this response.

Wednesday, Apr. 12, 1944. No change was noted. The patient still revealed a marked apathy and immobility. Once again, he was told that he would be fed and sheltered and that further interviews must be at his own request.

Thursday, Apr. 13, 1944. The same pattern of behavior was observed in the morning. At 1 p. m., he suddenly arose and asked for permission to shave and shower. He talked freely, appeared alert and cooperated with the wardmen. The physician compli-

mented him upon his rapid improvement, but he merely smiled in amusement. The patient then asked that his right ear be examined. A small furuncle was found in the external canal necessitating the application of phenol and glycerine drops. The patient offered profuse thanks for the treatment and happily entered the physician's office. He was spared from further questioning but he listened attentively to a case history of hysterical pseudo-dementia taken from Henderson and Gillespie's text of psychiatry. He was quite amused and laughed heartily at the conclusion of the reading. Upon direct order, he obediently arose, walked back to his room and requested comic magazines from the ward attendant.

Friday, Apr. 14, 1944. The patient awoke early and enjoyed a full breakfast. He spoke coherently and relevantly and exhibited a normal emotional display. He protested that his mind was still confused and that he possessed no knowledge of his activities during the past few weeks. He gaily denied giving intentional approximate answers and laughed when told of his previous responses. Sensory examination showed that he still possessed a bilateral glove anesthesia.

His improvement continued, and he showed much more attention to his personal cleanliness. He asked to be released to face trial, but refused to see the officer who had been assigned to act as his defense counsel. He demanded that he defend himself and appeared confident that he would be judged not guilty. He glibly spoke of going overseas into actual battle. After twenty-one days of hospitalization, he was finally discharged to the guardhouse on Apr. 27, 1944.

The soldier would not cooperate with his defense counsel, steadfastly insisting that he was a victim of amnesia. At the trial, he once again appeared lethargic, emotionally blunted, stared blankly at the board members, and mumbled, "I don't know" to all questions. The psychiatrist declared him mentally responsible for his delinquency and mentally competent to face trial. He was found guilty. Back in the guardhouse, he proudly boasted about his dramatic performance at the court martial, but settled down and accepted the duties of a garrison prisoner.

On the evening of May 18, 1944, he and two other prisoners escaped from the guardhouse. The following night, the writer discovered the soldier casually waiting near the psychiatric ward, and was asked for an interview. Unwashed, unshaven, clothing wet and filthy, the soldier quietly told of his hiding in the tall grass for twenty-four hours, although it had been raining all day. He had decided to

surrender to authorities but had chosen the writer to be the benevolent intermediary. After a warm shower and hot coffee, he relaxed and became verbose.

"I can put it over any doctor. I had you going too. When you read that story to me (referring to the case history of pseudo-dementia), I had to laugh and give in. But honest, I don't remember a thing when I was A.W.O.L. I must have lost my mind. I'm a good soldier now, and I proved it by giving up to you. I'm no good to the army in the guard house. Give me my discharge or put me overseas."

DISCUSSION

Social service investigation revealed that the soldier had had several common law wives, drank alcohol to excess and had been a prizefighter. He had received a high school education but had drifted from job to job in civilian life. Prior to his absence without leave, he had been a fairly good soldier, a cocky member of the military police. Many aggressive and social traits of a psychopathic personality were prominent.

The case presents the features of hysterical anesthesia, hysterical pseudo-dementia, the Ganser syndrome, and the soldier's own confession of malingering. The tendency to demarcate conscious behavior from the unconscious, as two distinct entities, may be as erroneous as the archaic division of the soma from the psyche. The human being is a dynamic personality, constantly being motivated by the two levels of cerebral activity; and the final performance is the interaction of conscious and unconscious stimuli.

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THE GOODENOUGH TEST AS APPLIED TO ADULT DELINQUENTS *

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Asking an adult delinquent to draw his very best picture of a man is perhaps one of the most personally revealing things that you can have him do. At the outset you must make it clear that you want him to sketch-in a complete drawing or probably he will make only a partial picture. Usually, after about five minutes drawing time, he will hand you his pictorial representation of a man. And what will this be most likely to resemble? Will it look like his outward appearing self, as he would be recorded by a camera lens? Usually not! More frequently than is ordinarily suspected, he has given unknowingly a much deeper roentgen ray-like picture of certain of his dominant inner-self characteristics. In other words, in working out his sketch, he has given no thought to reflecting his physical appearance, but oftentimes unwittingly has projected concealed personality tendencies of a decidedly tell-tale nature. For this reason, the Goodenough "Draw-a-Man" test is gaining recognition as being essentially a projective technic in personality study.

Goodenough's book, entitled "Measurement of Intelligence by Drawings" was published in 1926 (12). Through an objective analysis and comparison of drawings from several thousand school children, Goodenough succeeded in developing a scoring method quite well suited for estimating the intellectual maturity of children up to about the onset of adolescence. Her findings, and those of earlier investigators, showed conclusively that the human figure drawings of young children reflected an intellectual component rather than an esthetic component and that such pictorial representations are based primarily on a concept formation factor, rather than on visual imagery and manual skill. In her book, Goodenough expressed the opinion that a test of this kind might be re-standardized in other ways for clinical diagnostic purposes.

In more recent years numerous articles (1, 2, 4, 7, 8, 13) have

* Paper read before the 77th Annual Congress of Correction of the American Prison Association, Long Beach, California, September 12, 1947.

appeared in the literature dealing with the Goodenough "Draw-a-Man" test findings on children and adults as investigated under both normal and abnormal conditions of health. A very recent article by Brownell, which appeared in the March 1947 issue of the American Magazine, was entitled "How Do You Draw A Man?" Without supporting statistics, this article discussed certain projective properties of the test as had been discovered through its use at New York University's Testing and Advisement Center. The Goodenough "Draw-a-Man" test has been featured in two previous Medical Center studies. The writer of this paper published a short article in 1944 entitled "The Use of the Goodenough Test for Revealing Male Homosexuality" (9). Also, he is a co-author of another article in publication at the present time entitled, "Homosexual Activity, Relation of Degree and Role to the Goodenough Test and to the Cornell-Selectee Index" (3). The subject matter of these two articles primarily dealt with the topic of male homosexuality as related to the observed tendency of these subjects to project feminism into their Goodenough drawing-a-man pictures.

The administration of the Goodenough test to adult delinquents at the Medical Center was begun in 1940. To date, our psychologic files contain more than 3,000 of these drawings. From the very beginning it was apparent that this simple, quickly administered drawing test frequently afforded the means by which one could secure highly personalized projective manifestations of probable diagnostic significance. Special scoring criteria were set up for these obvious projections as they were detected from time to time. In 1944, the Goodenough Test was included in a special battery of tests * set up for administration to new incoming patients. The pictorial representations of the male human figure made by the first 1,000 subjects so examined with this test battery were evaluated by means of our formulated diagnostic criteria.

The scored Goodenough drawing material for our first 1,000 cases was statistically evaluated from two different points of view: namely, the level of tested intelligence and the psychiatric diagnosis. An abbreviated form of the Wechsler-Bellevue scales was used for the intelligence determinations (10). To facilitate statistical presentation, a three-fold intelligence scheme was adopted instead of attempting a separate statistical treatment for all of the seven levels of Wechsler-Bellevue classified intelligence. The IQ range, the number and per cent of total group, and the mean IQ scores for

* In addition to the Goodenough test, this test battery consisted of an abbreviated Wechsler-Bellevue scale, the revised Rorschach multiple choice test, and the Cornell-Selectee index.

those subjects included under each of three broad levels of classified intelligence are shown by table 1. Indicated are mean IQ scores of 120.9 for the above average intelligence group, 100.0 for the average intelligence group and 77.2 for the below average intelligence group.

Also, to facilitate statistical analysis and presentation, the psychiatric diagnoses on our first 1,000 subjects were categorized by a psychiatrist into nine groups as shown in table 2. In this paper, for sake of brevity, the letters PP will be used to designate psychopathic personality.* For the nine psychiatrically classified groups, table 2

Table 1

DATA BASED ON INTELLIGENCE CLASSIFICATION FOR 1000 ADULT DELINQUENTS

Intelligence Classification	I.Q. Limits	No. Cases	% Total Group	Mean I.Q.
Above Average	111 and over	220	22.0	120.9
Average	91-110	380	38.0	100.0
Below Average	0-90	400	40.0	77.2

Total Group Mean I.Q. 95.5

Source: U.S. Medical Center for Federal Prisoners, Springfield, Missouri.

reveals data as pertaining especially to intelligence, age and claimed school grade completed. In regard to intelligence special attention is called to the fact that with the exception of the Mental Deficient Group, essentially average intelligence is indicated by the mean IQ scores of the remaining groups. Therefore, it should be remembered throughout this paper that any significant intergroup differences on our scored diagnostic criteria must be ascribed as primarily due to the diagnosed psychiatric condition *per se* rather than due to an intelligence factor. This remains true even in those instances where

* The full unabbreviated psychiatric classification for the four indicated psychopathic personality groups are as follows: Psychopathic personality with pathologic sexuality (PP Homosexual Group), Psychopathic personality with pathologic emotionality (PP Emotional Group), Psychopathic personality with asocial or amoral trends (PP Asocial Group) and Psychopathic personality mixed types (PP Mixed Group).

the scored criteria has been showed to be directly influenced by an intelligence factor because of the approximate equalization of tested intelligence throughout the variously classified diagnostic groups.

Other tabulations under table 2 show a mean age of 30.1 years for the total group of 1,000 subjects. The mean ages of the psychiatrically classified groups ranged from 24.0 years for the PP Emotional Group to 33.2 years for the group labeled Others, which is made up almost entirely of psychoneurotically disturbed personalities. For the total group the claimed mean school grade completed

Table 2

DATA BASED ON PSYCHIATRIC CLASSIFICATION FOR 1000 ADULT DELINQUENTS

Psychiatric Classification	No. Cases	% Total Group	Mean I.Q.	Mean Age	Mean Grade Completed
Organic Group	60	6.0	89.4	32.5	7.5
Psychotic Group	97	9.7	92.5	32.4	7.4
P.P. Homosexual Group	91	9.1	96.1	25.0	8.4
P.P. Emotional Group	83	8.3	101.5	24.0	8.7
P.P. Asocial Group	86	8.6	100.8	32.8	8.1
P.P. Mixed Group	115	11.5	99.9	26.3	8.3
Simple Adult Maladjustment Group	354	35.4	97.1	32.3	8.1
Mental Deficient Group	47	4.7	61.1	25.1	3.9
Others Group	67	6.7	98.5	33.2	7.8
Total Group	1000	100.0	95.5	30.1	7.9

Source: U.S. Medical Center for Federal Prisoners, Springfield, Missouri.

was 7.9. The lowest claimed mean school grade completed was 3.9 for the Mental Deficient Group and the highest 8.7 for the PP Emotional Group.

The task of diagnostically evaluating the drawings of these adult delinquents was not difficult. Along the bottom edge of each of the plain white drawing sheets appeared a row of letter symbols designating the various diagnostic criteria selected for investigation. While looking at the drawing, only those lettered symbols considered appropriate for the subject's graphically expressed projections were encircled. With a good understanding of the real significance of the diagnostic criteria, such evaluative judgments can be made quite promptly on an impressionistic basis with attention primarily being focused on the drawing's total configurational appearance.

PRIMITIVITY AND MATURITY

It has been shown by Goodenough and others that when a normal child makes a drawing of the human figure, its appearance well expresses his present stage of mental maturity. Her findings showed that this test had an average correlation of .76 with the Stanford-Binet mental age for chronologic ages 4 to 12, taken separately. However, the investigator's earlier four and one-half years juvenile court experience has been such as to indicate that this does not hold true when the test is applied to young delinquent subjects who are seriously warped or disturbed emotionally. The markedly subnormal scores attained by such juvenile delinquents on a test of this sort made it obvious that this test could not be used reliably for estimating a delinquent child's probable level of Stanford-Binet intelligence. Instead, it seemed that this simple drawing test had screened those young delinquents in whom a serious emotional arrest had occurred even though the intellectual growth had continued at an unretarded rate.

Our findings for adult delinquents show a preponderance of drawings scored for child-like primitivity over adult maturity. Figure 1 is a drawing made by a feeble-minded subject with an IQ of 59. His drawing typifies the natural primitivity to be expected from subjects of low grade intelligence. Figure 2 is a drawing reflective of full adult conceptual maturity and was made by a subject of average intelligence—IQ 106. A primitive child-like conceptualization is portrayed in figure 3 by a subject of average tested intelligence—

Fig. 1

Fig. 2

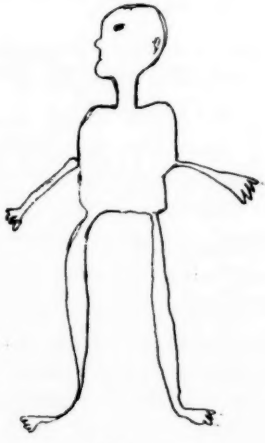


Fig. 3

GRAPH 1

Figure A

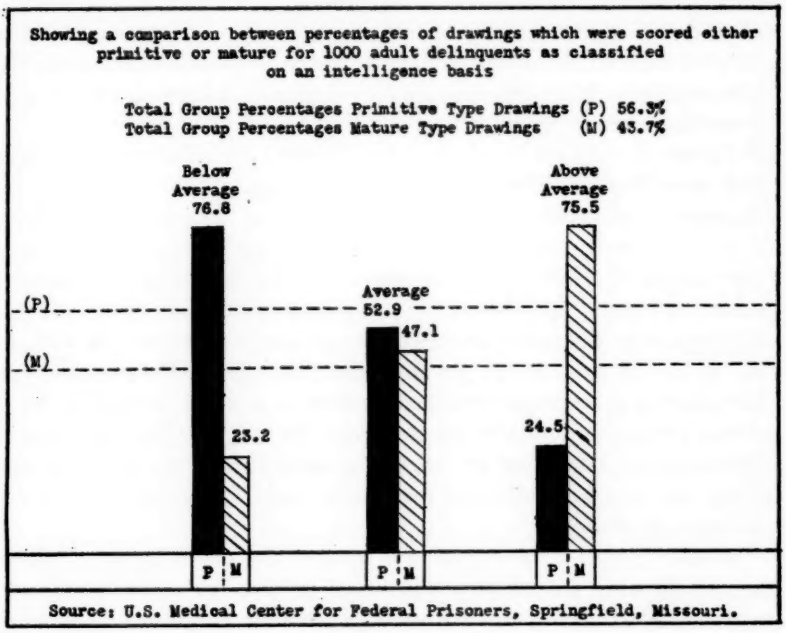
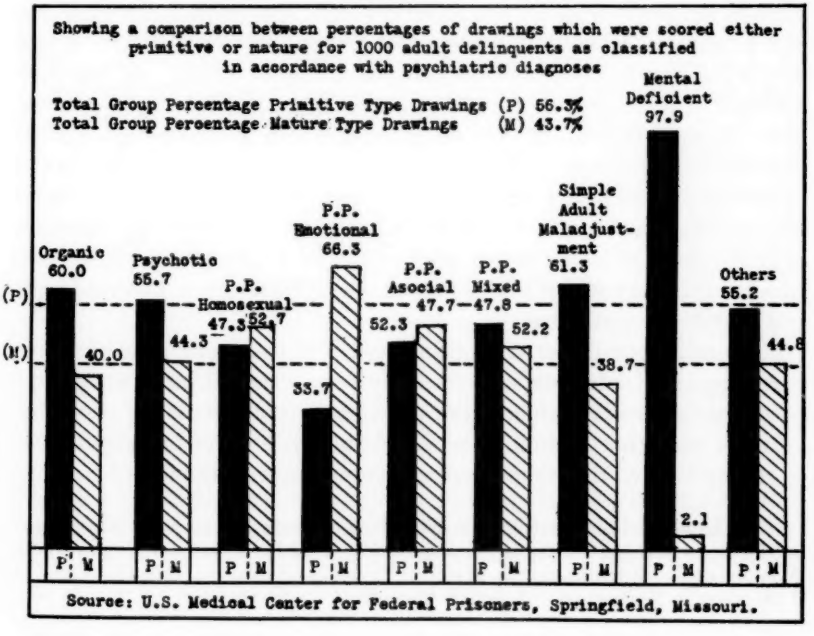


Figure B



I.Q. 108. A finding of this sort is not an uncommon occurrence in adult delinquent subjects. In such cases this seemingly is a graphic reflection of an arrested emotional maturation. The findings of this study as well as those of an earlier Medical Center study with the Rorschach test (11) provide highly suggestive evidence of this lack of emotional maturation.

Graph 1, Figure A shows the percentages of drawings which were scored as primitive or mature for our group of 1,000 adult delinquents as classified on an intelligence basis. From the standpoint of the total group, 46.3 per cent of the drawings were scored as primitive in type, thus leaving 43.7 per cent of the drawings scored as mature in type. Approximately three-quarters of the below average intelligence group made primitive drawings; in contrast, three-quarters of the above average group made drawings of the mature type. For subjects of average intelligence, there is a slight balance in favor of the primitive over the mature type drawings. The two broken horizontal lines crossing the bar areas signify, in respect to the total group, the plotted positional percentage lines for primitive and mature type drawings.

Under graph 1, figure B, are shown the percentages of drawings which were scored as primitive or mature for adult delinquents as classified in accordance with the psychiatric diagnoses. Excluding the Mental Defective Group, the groups showing a noticeable elevation of the percentage of the primitive over the mature drawings are the Organic, Psychotic, Simple Adult Maladjustment and the group labeled Others. The PP Emotional Group stands in an even sharper opposite contrast with a percentage of 66.3 mature drawings as against 33.7 primitive drawings. In fact, there are true significant statistical differences in the percentages * of primitive drawings indicated for the PP Emotional Group as related to those of the Organic, Simple Adult Maladjustment and Psychotic Groups. The Mental Defective Group gave a total of 97.9 per cent primitively scored drawings which is in keeping with expectations from subjects with deficient intelligence.

By means of the criteria just presented, you have seen how this large group of adult delinquents have been screened into two groups —one which made human figure drawings characteristically primitive in type, the other mature in type. Although not yet investigated, it is the opinion of the writer that this sort of screening might be of aid

* The method of determining statistically significant differences of percentages in this paper was that described by Robert Schrek, M.D., in his article entitled "A Nomogram for Determining the Statistical Significance and the Probable Error of Differences of Percentages." J. Lab. & Clin. Med. 25:180-184.

in selecting those subjects who might profit most from psychotherapy. This is based on the assumption that those subjects who make drawings expressive of child-like primitivity, even though intellectually adequate, are living emotionally at a level much too low to permit the most hopeful response to present day psychotherapy. On the other hand, it would seem that those subjects who have made drawings expressive of adult-like conceptual maturity should be expected to respond more favorably to psychotherapy, particularly if such effort be directed toward the specific areas of maladjustment within the structural framework of the total personality.

One of the earliest selected diagnostic criteria for evaluating drawings made by adult delinquents is that termed disintegration. Early noted was the ready tendency for the occurrence of disintegrative projections in the human figure drawings of paretic, psychotic and senile patients. Figures 4 through 9 are samples of drawings made by patients who for one reason or another are disintegrating, who figuratively speaking might be said to be "falling apart at the seams."

Fig. 4

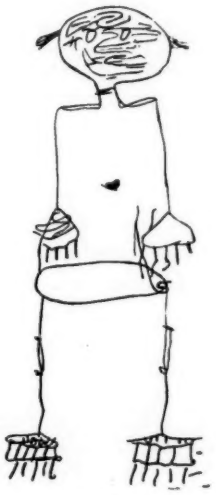


Fig. 5

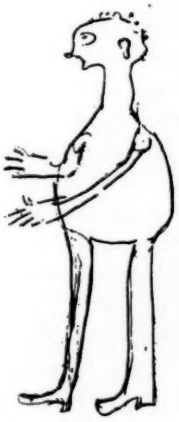


Fig. 6

Figure 4 is the drawing of a 53 year old deteriorated paretic patient. Figures 5 and 6 characterize the type of drawings frequently obtained from patients undergoing senescence. The figure 7 drawing was made by a catatonic patient, figure 8 by a 55 year old arteri-

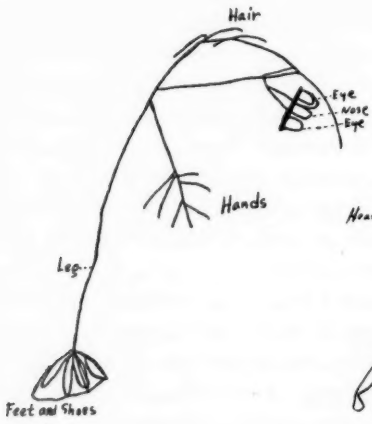


Fig. 7

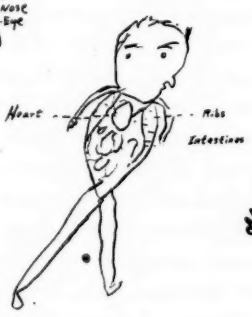


Fig. 8

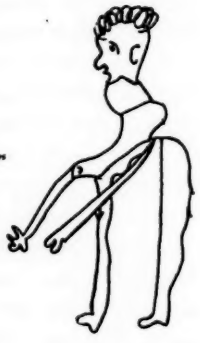


Fig. 9

osclerotic patient, and figure 9 by a 42 year old psychotically disturbed patient with syphilis of the central nervous system.

Graph 2, figure A reveals that 21.4 per cent of our adult delinquents made drawings which were scored for disintegration. There is a quite noticeable tendency for a lowering of the percentage of disintegrated drawings as the intelligence becomes greater. Under graph 2, figure B are shown the percentages of drawings that were scored for disintegration as classified in accordance with psychiatric diagnoses. The Organic Group led all other groups in this respect with 33.3 per cent. Near the total group percentage line of 21.4 falls the Simple Adult Maladjustment, the group labeled Others, the PP Asocial, the Psychotic and the PP Mixed Groups. The groups showing the lowest percentages for disintegration were the PP Emotional, the PP Homosexual and the Mental Deficient Groups. In scoring the drawings of Mental Defectives for disintegration, due allowance was made for their naturally limited synthesizing ability.

In the study group of 1,000 cases there were 71 subjects who had an age of 50 years and over. The tabulations revealed, for this group of oldsters, a Mean age of 57.5 years, a Mean IQ of 100, and a disintegration score of 62 per cent. Similar tabulations were made on a selected younger aged group of 71 subjects who were matched as closely as possible with the oldsters on a man to man basis for both IQ score and psychiatric diagnosis. As so matched, this group of youngsters showed a Mean age of 24 years (range 19 to 29 years), a Mean IQ of 100, the same as was indicated for the oldsters. The tabulations showed that only 7 per cent of the youngster's drawings

GRAPH 2
Figure A

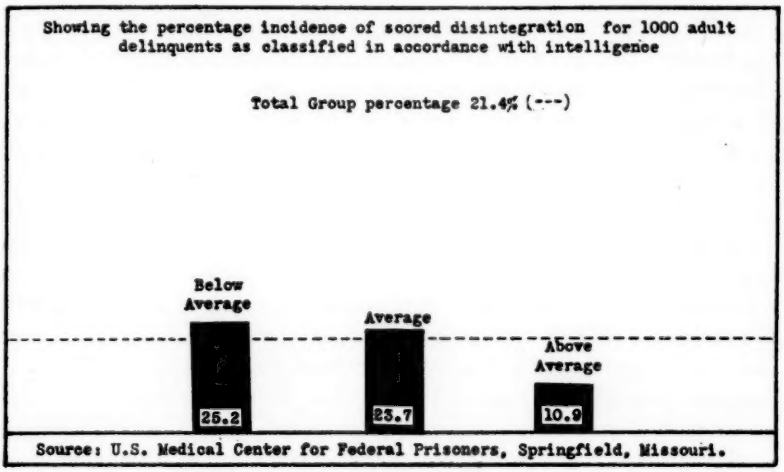
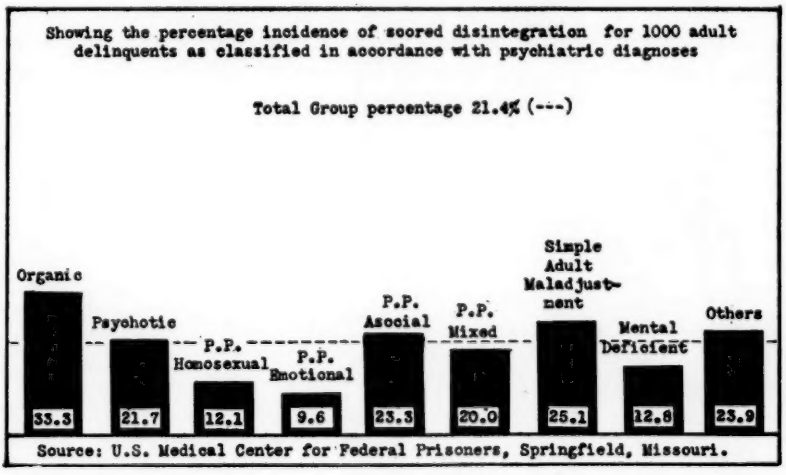


Figure B



had been scored for disintegration as contrasted with the 62 per cent so indicated for the oldsters. This difference of percentages is sufficiently great to satisfy rigid requirements of statistical significance. By such findings the Goodenough "Draw-a-Man" test is shown to be an extremely sensitive instrument for revealing disintegrative projections of senility.

CLOTHING

Still another way of evaluating a delinquent's drawing concerns the matter of whether or not clothing details are adequately handled. Generally speaking, when the figure is roughly sketched in the nude or partially clothed, it becomes a sign of primitive conceptualization. In general, our findings indicate that as intelligence increases there is a corresponding increase in the amount of clothing detail showed.

Figure 10 portrays a drawing reflective of both high regard for clothing detail and adult conceptual maturity. The intelligence rating for this subject was bright normal—IQ 115. Figure 11 illustrates the limited regard for clothing detail which is in keeping with this subject's rating of borderline intelligence—IQ 78. An utter lack of proper regard for clothing considerations in a subject of average tested intelligence—IQ 103—is shown by figure 12. The psychiatric diagnosis for this case was Simple Adult Maladjustment.

Graph 3, figures A and B show the percentages of inadequately clothed figures made by delinquent adults as classified in accordance with intelligence and psychiatric diagnoses. More than one-half of the entire group of 1,000 subjects made drawings which were scored as inadequately clothed. Under figure A, one can see at a glance the close relationship existing between the level of tested intelligence and

Fig. 10

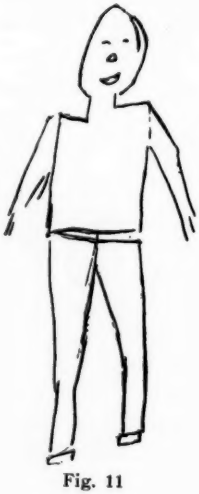


Fig. 11

Fig. 12

the regard for clothing detail. A statistically significant difference in the percentages of inadequately clothed figures is shown for the Below

Average Group as considered in relationship to the Above Average Group.

Under graph 3, figure B are given the percentages of inadequately clothed human figure representations made by the subjects of this study as classified in accordance with psychiatric diagnoses. The Mental Deficient, Simple Adult Maladjustment, Psychotic, Organic and PP Asocial Groups all showed elevated percentages of

GRAPH 3

Figure A

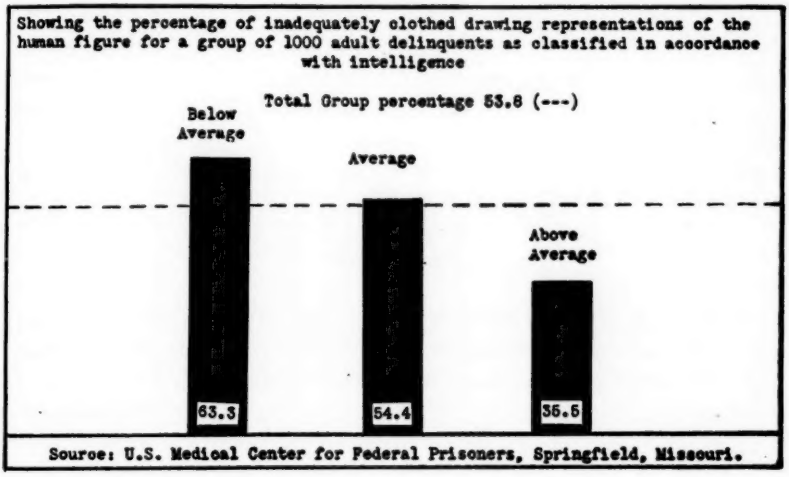
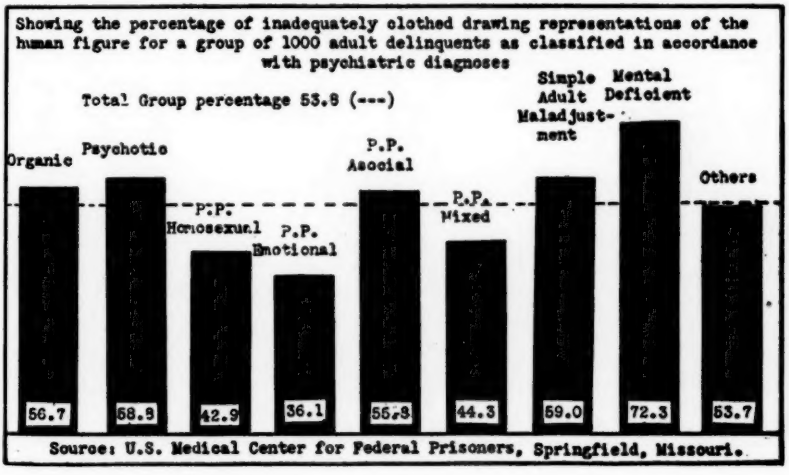


Figure B



inadequately clothed drawings. On the other hand, the PP Emotional, the PP Homosexual and the PP Mixed Groups showed noticeably lowered perçentages of inadequately clothed figures. Statistically significant differences of percentages are indicated between the PP Emotional Group as considered in relationship to both the Simple Adult Maladjustment and Psychotic Groups. Similary, significant differences of percentages are indicated for the Mental Deficient Group as related particularly to the PP Homosexual, PP Emotional, and PP Mixed Groups.

In the way of a brief summary of the findings for inadequately clothed figures, it may be stated that as the level of intelligence increases a corresponding increase of clothing detail is to be expected. However, in cases where there is a noticeable lack of clothing representation in the presence of adequate tested intelligence, then it becomes a sign of maladjustive import indicative of probable emotional immaturity.

POSTURING

Elkisch (5, 6) has had two recent publications dealing with certain formulated diagnostic criteria for evaluating children's free drawings and paintings. In her studies she stressed the importance of graphic form expressions of flexibility and rigidity. Flexibility was considered a sign of emotional adjustment, rigidity a sign of emotional maladjustment. Of her four listed pairs of opposite criteria for evaluating children's drawings, this is the only one that the writer

Fig. 13

Fig. 14

Fig. 15

GRAPH 4
Figure A

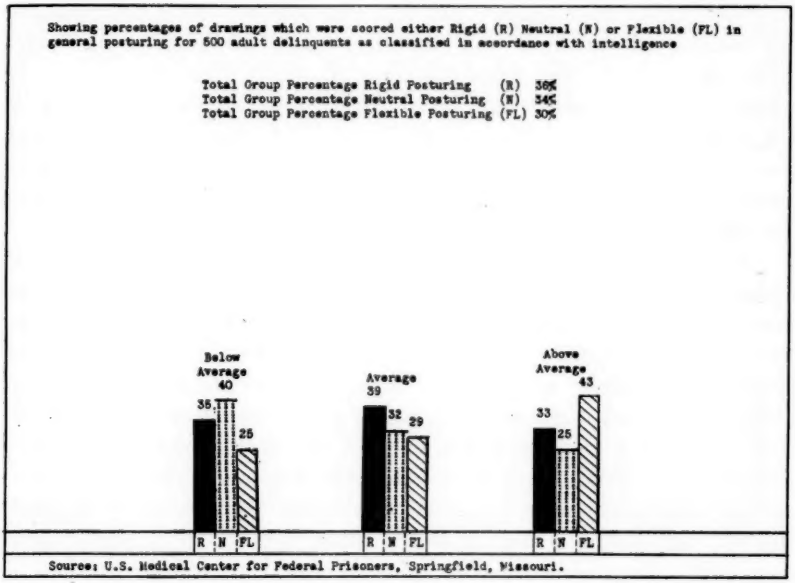
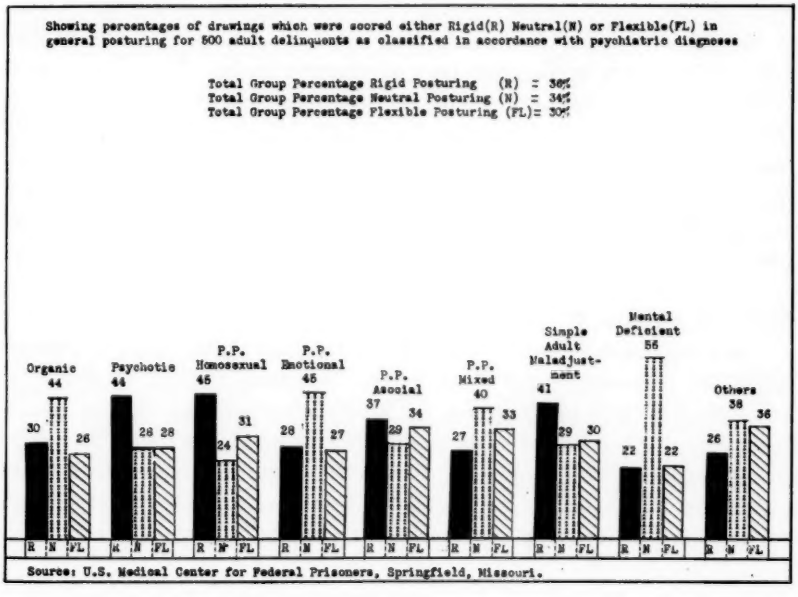


Figure B



had not independently formulated for his evaluation of human figure drawings by adult delinquents. Time did not permit a study of all our first 1,000 drawings for postural expressions. As a consequence, an analysis was made of only the second half of the series of 1,000 drawings. These 500 drawings were scored in regard to stance or posture as rigid, neutral or flexed. Figure 13 depicts an extremely rigid type of stance. Figure 14 shows a drawing which was scored for a natural flexibility of stance while figure 15 represents a more neutral type of stance between flexibility on the one hand and rigidity on the other.

Under graph 4, figure A are shown the percentages of adult delinquent drawings which were scored for postural expression as rigid, neutral or flexed in accordance with classified intelligence. For the total group there is a near equivalent percentage incidence of drawings scored for each of these three forms of postural expressions. Also to be noted is the near equivalent percentage incidence of drawings scored for rigidity within each of the three levels of classified intelligence. This finding shows that the Rigidity Criterion, suggestive of emotional maladjustment, is not influenced by an intelligence factor. However, in regard to the other two forms of postural expression, a noticeable trend is indicated for a greater percentage of flexible posturings as the intelligence increases thus directly resulting in a corresponding drop in the percentages of neutrally scored posturings.

Graph 4, figure B reveals the postural percentage scores for adult delinquents as classified on a psychiatric basis. The highest percentages of rigid posturings occurred in the PP Homosexual, Psychotic, Simple Adult Maladjustment and PP Asocial Groups. All the remaining groups were relatively undifferentiated in regard to their considerably lowered percentages of drawings scored for rigidity. In regard to expressed rigidity, statistically significant differences of percentages are indicated for the PP Homosexual Group as considered in relationship to both the PP Emotional and the Mental Deficient Groups.

In a summarizing way, it may be stated that the Rigidity Criterion indicative of maladjusted emotionality has characterized 36 per cent of this adult delinquent group. The findings indicate that its manifestation is not influenced by an intelligence factor. The PP Homosexual, PP Emotional, Psychotic, Simple Adult Maladjustment and PP Asocial Groups all tend to give elevated percentages of drawings scored for expressions of ridigity.

FEMININITY

An appreciable amount of evidence has been obtained at the Medical Center to indicate that the Goodenough "Draw-a-Man" test can be used as a projective tool for the revealing of homosexual tendencies. Our studies have shown that for known homosexuals nearly

Fig. 16

Fig. 17

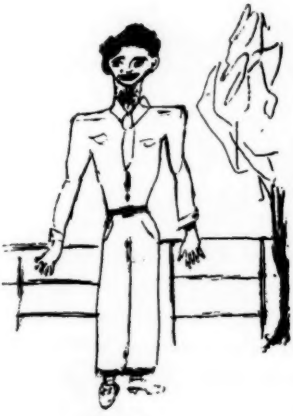


Fig. 18

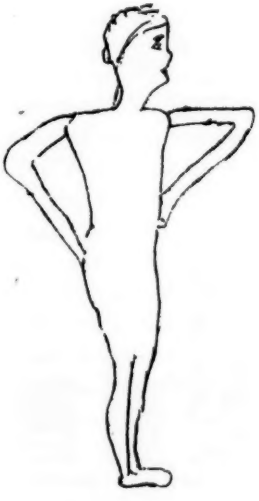


Fig. 19

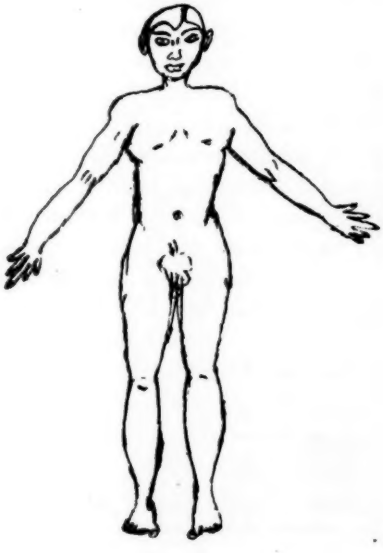


Fig. 20

Fig. 21

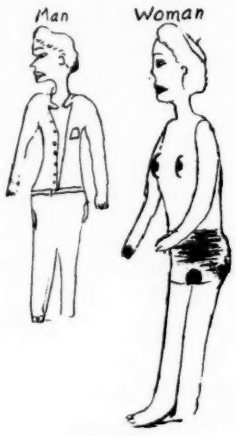


Fig. 22

Fig. 23

a half will project unmistakable femininity into their drawing-a-man pictures, such as curved figure, Cupid's bow mouth, accentuated eye, hand and hair details, relatively short arms, large hips and small feet. Our studies have shown that, even though all known homosexuals do not project feminine characteristics in their drawings of a man, whenever one encounters a male adult delinquent who draws the man-figure with feminine characteristics, it is a highly significant indication of a strong feminine component in the personality structure.

Figures 16 through 23 are drawings made by known homosexually inclined subjects. They illustrate the femininity projections so frequently encountered in these patients. Figure 16 is the man-figure drawing by a 26 year old subject. The psychiatric report described him as showing the symptoms of a long-standing psychoneurosis with severe psychosexual conflict. He assumes the passive role in homosexual relationships, and occasionally has submitted for monetary considerations. Figure 17 is the man-figure drawing made by a 22 year old psychopath who is a confirmed homosexual. There is a history of fellatio, the use of lipstick and make-up. Figure 18 is the man-figure drawing which was made by a 22 year old psychopath. He is an admitted homosexual. In the psychiatric report he was described as effeminate in speech and mannerisms. It was mentioned that he shaved the hair from his chest, extremities and upper abdomen in the attempt to appear as feminine as possible. Figure 19 shows the man-figure drawing by a 24 year old psychopath who readily admits a considerable history of homosexual activity. In the psychiatric appraisal of his personality make-up he was described as effeminate, soft-voiced, immature and inadequate. Figure 20 was

made by a 23 year old Negro subject with a history of homosexual activity beginning at the age of 14.

Figures 21 and 22 show, side by side, the man and woman figures as drawn by two young homosexually inclined psychopaths. These drawings well portray the difficulty encountered by such subjects when attempting to pictorially differentiate the two sexes. Figure 23 is

GRAPH 5

Figure A

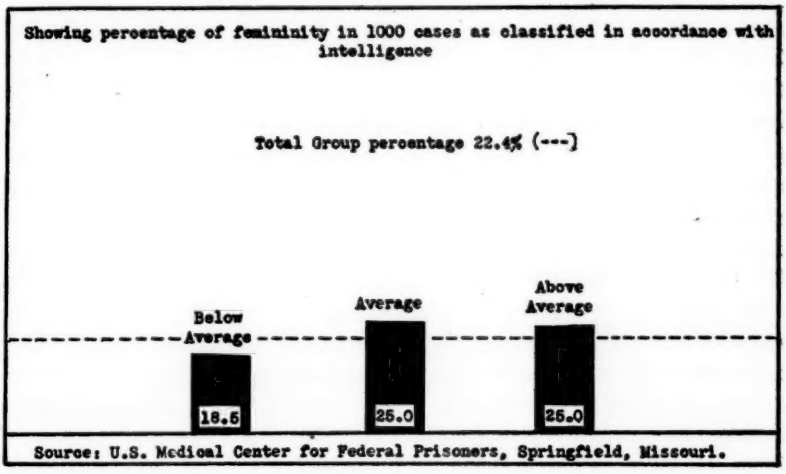
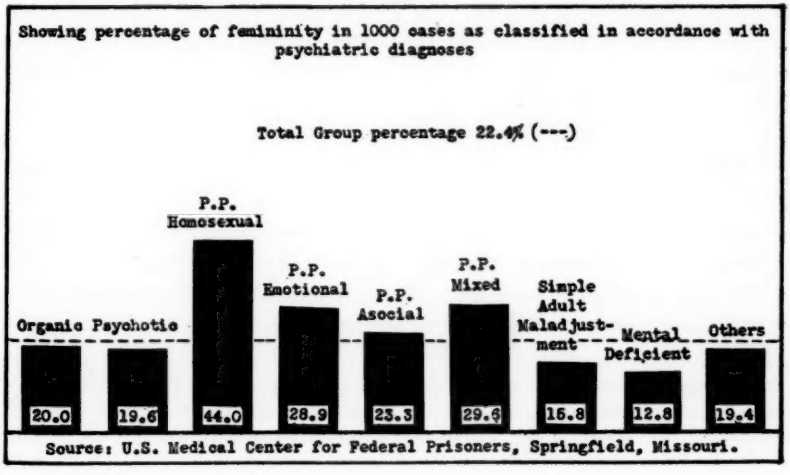


Figure B



another drawing by a young psychopath which is presented for the purpose of illustrating what has been scored as compensated masculinity. The tendency to express compensated masculinity in conjunction with recognizable femininity occurred in 13 per cent of the drawings by the Homosexual Group whereas the percentage score in this regard for the Total Group of 1,000 cases was 7 per cent.

Graph 5, figure A reveals the percentage incidence of scored femininity in the drawings of our adult delinquents as classified in accordance with intelligence. For the Total Group 22.4 per cent of the cases were scored for femininity. By and large, the Femininity Criterion is shown to be little influenced by an intelligence factor with percentage scores of 18.5 for the Below Average Group and 25.0 for both the Average and Above Average Groups.

Under graph 5, figure B are shown the percentages of cases which were scored for femininity in the variously classified psychiatric groups. Especially noteworthy is the fact that all of the four psychopathic personality groups obtained the highest percentage scores for femininity, the PP Homosexual Group in particular giving the high total of 44 per cent. The lowest percentages for femininity were 12.8 and 15.8 for the Mental Deficient and Simple Adult Maladjustment Groups, respectively. The differences of percentages indicated for the PP Homosexual and Simple Adult Maladjustment Groups are highly significant statistically. The differences of percentages indicated between the PP Homosexual Group on the one hand as against either the Psychotic or Mental Deficient Groups on the other hand just falls short of true significance. However, the differences of percentages for the PP Homosexual Group as considered in relationship to the Total Group meets rigid requirements for statistical significance. By such findings it may be concluded that the Goodenough test is an especially effective instrument for the screening of homosexually inclined delinquent subjects.

All in all, a total of 28 diagnostic criteria were used for the purpose of evaluating the human figure drawings of our adult delinquents.* The time allotted to this paper has permitted a discussion of only a limited number of these. It is believed the few criteria discussed will sufficiently indicate how readily this test permits projective personality manifestations of diagnostic importance.

* Certain criteria not discussed in this paper showed the following percentage scores for the Total Group and more particularly for the psychiatrically classified subgroups which attained the highest and lowest positional ranks.

	Total Group %	Highest Subgroup %		Lowest Subgroup %	
Overt Action	12.7	PP Emotional	15.7	Organic	5.0
Theme	4.4	Psychotic	8.3	Mental Defective	0.0
Absurd Deviations	30.9	Mental Defective	61.7	PP Emotional	21.7
Strongly Masculine Type	27.6	Others	34.3	Mental Defective	14.9
Primitive Neuter Sexed	19.6	Mental Defective	53.2	PP Mixed Type	10.4
Genitalia Portrayed	3.0	Psychotic	7.2	PP Asocial, Mental Defective, Others	0.0
Miniature Drawings	10.1	Organic	18.3	Psychotic	3.1
Nipples Shown	4.8	PP Homosexual	9.9	Others	1.5
Navel Shown	4.8	PP Homosexual	7.7	Mental Defective	2.1
Presentation, Full-Faced	44.5	PP Mixed Type	53.9	Psychotic	34.0
Presentation, Profile	18.0	PP Emotional	34.9	Mental Defective	0.0
Presentation, Mixed	37.5	Mental Defective	53.2	PP Emotional	18.1
Artistic Talent	6.6	PP Asocial	12.8	Mental Defective	0.0

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ON SCHIZOPHRENIA*

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I have chosen this theme for today's address owing to various reasons which I deem worthwhile. Primarily, because this mental affliction is still a disease which continues mostly to attack the adolescent, giving a higher percentage of cases than all the other mental derangements put together, secondly, because, in spite of the lengthy and detailed observation of practical cases a great number of colleagues continue to mistake this mental affliction with the Kraepelinian dementia praecox and lastly, because it is still a most sourceful field of investigation from which we may extract valuable material with a view to the edification of future psychiatry. I, therefore, yield once more to my interest in this respect and as the result of my experience and observation throughout a lengthy period of association in daily contact with the mentally deranged and with a large number of schizophrenic patients, above all, more than from mere bibliographic inquiries.

I. SCHIZOPHRENIA AND DEMENTIA PRAECOX

Once again I must emphasize the definite divisional line which exists between *dementia praecox and schizophrenia,* an essential and unmistakable difference in their constitutional, clinical and anatomopathologic aspects. The only point they have in common is the fact that they generally appear during the age of adolescence, but such a contingency cannot be seriously contemplated from a scientific standpoint to justify the confusion of two distinctly different maladies under a single diagnosis.

Dementia praecox,* such as we have known it to be since the beginning of our practice, about a quarter of a century ago, is: (1) a dementia; (2) precocious in its appearance or manifestations, i.e., a primitive dementia and, on appearing as a mental affliction carrying its own trade-mark, the stigma of its incurability; it was always considered a *precocious dementia* despite the fact that it had more or less important phases of abatement, of longer or shorter duration.

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It is true that Kraepelin assembled a group of patients for the purpose of *prognostication;* hence the artificiality of the group of "dementia praecox subjects"; for there were amongst them besides other clinical forms, cases of positive dementia praecox, including our future *schizophrenic patients.* Strange to say, however, many of the initial clinical manifestations both in the young *dementia praecox* subjects and in the young schizophrenic cases are due, not to the disease itself, but to their *puberty,* either exalted or deviated, but unmistakably due to their special state of puberty. Hence, in the nosographic descriptions between both diseases we often find resemblances which amaze us. Let us not forget, however, that such a similarity is not of the disease in itself but most definitely a similitude of *pubescence.* Therefore, we find it is the adolescent or pubescent who resembles each other, not the diseases dementia praecox and schizophrenia. This is the basic and fundamental point. As for the rest, we shall forthwith develop in more detail.

The old conception of *dementia praecox* was thus confronted by Kraepelin himself:—"The importance of our diagnostical process shall reside, therefore, in the fact that we, during the initial stages of the disease, can predict with fairly accurate probability its termination in a particular state of *exhaustion*". He then affirmed that the dementia praecox patients have, in common, fundamental lesions in the sphere of their feelings and will-power. Lange recalls too that "the schizophrenias were grouped by Kraepelin under the heading of 'dementia praecox' a designation which entails the conception of their precocious appearance and their course of progress which usually *ends in dementia.*"

In order to fix again our dual judgment, besides remembering—I insist—our long experience, let us return to the scientific authors who established the fundamental and permanent conceptions with a psychiatric sense more clinical than bookish.

Regis reminds us that the old authors ". . . had observed that the subjects, after an intellectual flourishing more or less complete, underwent at the critical stage of their development a morbid perturbation which paralysed and *diminished* them mentally". He added that, "Serieux and Masselon have proven to us that such a decadence is due both to degeneration and to dementia, which thesis had already been foreboded by Pinel in 1809, by Esquirol in 1814 and by Spurzheim in 1818, who had placed these subjects under different categories which they entitled: accidental idiotism, accidental or acquired idiotism, *chronic dementia.*" It appears though that it was Morel who made the first exact description of what Willis, as early as 1672, had

observed, "in youths of high spirits, vivacious, animated and even brilliant in childhood who, upon reaching adolescence, fell into a state of obtuseness and torpidity". We might add that the definition "dementia praecox" belongs to the French genius who also gave us the most perfect description of this state of precocious decadence of the psychic functions taken as a whole, so fundamentally different from what we must call schizophrenia. Only later there sprang up in Germany Kraepelin's conception which, according to Regis, "has overstepped the mark and cannot be accepted without reservations." I believe that, in truth, Bleuler has merely changed the name of the Kraepelinian entity, maintaining the chaotic state of this veritable psychiatric stew, in which we must again try to find and separate what is really *dementia praecox*—according to Morel—and what is *schizophrenia.*

The former is always a dementia including anatomic substratum; the latter is a psychosis which may or may not develop into dementia, or become chronic or intermittent, etc., without anatomic lesions, properly speaking, according to Moyano.

So as not to recur to this conception I shall define the type of subject we have observed during so many years in hospitals and clinics, giving in advance several definitions so as not to allow ourselves, through inertia, to group under a single denomination that which represents two such dissimilar maladies.

According to F. L. Arnaud, this dementia praecox "is that which appears at the ages of 15 to 25 years. Following a somewhat brief, complex and variable period of delirium, we observe *the rapid dissolution of all then mental faculties;* such is the process of *dementia praecox.*"

It is idiopathic, precocious, for it attacks the young; it is also precocious because it follows rapidly upon the initial mental derangement, being recognizable as such from the commencement" . . . in such a manner—he asserts—as to be termed primitive, and also consecutive and terminal". According to Deny, it is as though "from a simple terminal or 'terminatif' state, as per Morel's definition, from the hereditary insanity of the degenerates, dementia praecox, were promoted to the category of a clinical entity, a most definite clinical entity with its triple sub-divisions:—hebephrenia—catatonic—paranoidic —characterized at first sight by the existence of a primal and swift weakening or deterioration of intellectual activity and possibly linked to a process of auto-intoxication of glandular origin."

According to Serieux, dementia praecox may be defined as a psychosis mainly characterized by "a special psychic weakening of a progressive nature, which appears during adolescence and ends by

annihilating all mental activity without ever jeopardizing the life of the patient".

At length, Masselon is of the opinion that dementia praecox begins in adolescence, and is distinguished by a *special and progressive weakening of the intellectual faculties,* developing more or less swiftly towards *simple dementia or through a process of stupor, agitation, excitement, or delirium more or less systematized.*

How is it possible thus to confuse an affliction so definitely clarified as our present schizophrenia (which we shall call "Claude type" in order to distinguish it from the Bleuler type) with the dementia praecox heretofore elucidated and clearly outlined with the aid of exact definitions by various authors? Have we not seen in our daily practice those *cases of dementia praecox* (outlined by Morel, Serieux, Masselon) from the very onset of their affliction, practically escape from under our hands sinking down towards the tragic abyss of insanity, *which was their fatal destiny from the very beginning,* whilst we must stand by powerless and watch their inevitable collapse?

Have we not also seen those other sufferers: refined, delicate souls reconcentrated or withdrawn into themselves, estranged, semi-aristocratic in mood and gesture, large bewildered eyes trying to grasp their new state, proud, somewhat pedantic, and vain, with an impassible expression upon their faces as that of a mask in ancient tragedies? These latter, the real and only schizophrenics, were born as such. Not so the dementia praecox subjects. They were not born thus but became so later.

II. SCHIZOPHRENIA

I claim in all formality the name of schizophrenia as belonging exclusively to the form of mental affliction which I shall set forth hereafter:—

(a) *Puberty:*

Schizophenia is the state of a morbid and prolonged pubescence just as senile dementia is a morbid senility.

Something of this was already foreseen by Regis when he affirmed that "the true pubescent psychoses, that is to say, in which the genital process plays a real and active part, are, above all, psychoses which take the form of mental confusion: acute hallucinatory psychoses, acute delirium, dementia precox (hebephrenia)". Then, orientating more towards schizophrenic forms, he adds: "than amongst the *psychoses arising out of puberty,* and which are, above all, hereditary and degenerative psychoses . . .".

The characteristic symptoms (signs) of the age of puberty have

so much resemblance to those described by psychiatrists as typical of schizophrenia that, logically, it has been found necessary to take account of these two coincidences: their beginning or evolution in puberty, and their symptomatology which is, in reality, that of an exaggerated and deviated pubescence.

There exist many explanatory theories of the characteristic symptoms so typical of the age of puberty, more boisterous and clamorous in the male than in the female. The principal ones would be, setting aside that of association, the physiologic, which takes into account the great and accelerated development of the central nervous system, and the maturing of the sexual glands. We recall, incidentally, that since the times of Justiniano and the Canonic Laws, legally this puberty stage commences at the age of 12 in the female and of 14 in the male. From the physiologic standpoint pubescence begins at the same age in both sexes, though there are the precocious and retarded puberty cases.

It has often been remarked upon the importance of the effect which the change of environment has upon the pubescent, with all its complications, amongst which I shall note as most valuable and interesting that one which compels the subject to create Oedipus conflicts owing to the subsequent blockading of the former free orientation existent in childhood. Büchler's "biological-teleological" theory, based upon the biologic goal of maturity which compels the pursuit of a sexual complement, might be a phase of such a state. Finality, Electivity and Efficacity are the three elements which, according to Hesnard, are integrated at the end of puberty. But these *must be gradually unfolded* (integrated) throughout the development of puberty on planes superated somatically and psychically. If pubescence be abnormal or too prolonged, as happens in the case of hereditarily disharmonious types, we already have the pathology of the pubescent age. Moreover, this should not surprise us at an age which is considered, with good reason, to be most *dangerous,* mounted, as it were, between two other stabilized ages: infancy and maturity. It is in truth the *critical age* so much like that other which brings decline and the entrance into an era also stabilized—senility. The pathology of puberty, according to Guy Larroche "is explained mainly as a transitory lack of equilibrium peculiar to this phase of life, which causes a general fragility of the organism and the fragility of each apparatus from a local standpoint."

"The general fragility"—he adds—"explains the facility with which children suffer from 'surmenage' ". When pubescence does not occur or when it is too retarded, there arise manifest signs of infantil-

ism which are not always complete. We all know that in the case of disharmonious individuals the development of the sexual glands and other auxiliaries (hypophysis, thyroids and suprarenal) and the central nervous and neurovegetative systems, generally, are not parallel, hence the birth of so many conflicts.

It is a period—according to Regis—far more extensive than is commonly believed, for it stretches "from 12 to 25 or 30 years of age", and—he adds—". . . is a critical phase for the brain of those individuals who are predisposed". We have all been witnesses if not actors in this veritable drama, for it has the elements of tragedy as well as comedy, which often causes a real divorce of generations: the pubescent does not understand the adult for he has not yet reached that age. The adults already do not understand the pubescent for they have ceased to be adolescents and have forgotten their own youth. The butterfly undergoes a state of amnesia in regard to the stage of chrysalis which it once was.

According to Nunberg, retarded puberty is found in *dis-social* individuals, or those who subsequently are afflicted with schizophrenia. This is what I have always found in practically all of my confirmed schizophrenic patients (not dementia praecox): a persistence of prepubescent characteristics, often infantile ones, above all psychic. *Their whole mental make-up is schematic.* Their psychic immaturity is notorious in face of the integration of their instinctive-affective life. Before the outer world, which brings pressure and constraint upon them, the world which considers them perverse, which does not allow them their primitive placid satisfactions: autoerotic, pre-incestuous or truly incestuous, they cannot act for they *are unable to act physiologically* with the ordinary psychologic mechanisms, and the conflict arises, that is, the side-solution: disease. And in disease again the "Ello" is triumphant. And as in its kingdom, dark and luminous at once, there is no exact notion of time and space, but of satisfaction or nonsatisfaction with termination or superation of stages through exhaustion of material and the appearance of other *centers of interest,* we find that in these patients *the past is always the present. The future, which is the natural offspring of their autism, of their imaginative vagrancy, is also the present to them.* And the worst of it is that amidst *this present* there hovers a giant, the subject himself. At his side Life marches on, undergoing its various stages, giving or taking, destroying and constructing, in a perpetual task of perfection. The subject ignores this "interlocked" in *one moment* of Living, as if, harking unconsciously to Goethe, he had succeeded in capturing and retaining that happy minute.

According to Blumenfeld, there are particular characteristics of this age; we note amongst them are "negative stubborness"; "destructive criticism"; "introversion"; "transformation of instinctive thinking to abstractions"; "solitary dreaming"; "pessimistic melancholia"; "religious conflicts"; "formation of personal ideas"; etc. As I have already mentioned, this author believes too that a number of features that at first sight are considered as typical of the age of puberty, are merely the result of special conflicts such as those of a sexual erotic nature, the call of generations and the religious-metaphysical conflict.

Here I recall an interesting symptomatologic observation: practically all schizophrenic young females, besides being leptosomic are also hyperthyroid, hyperovaric, hypertricosic: viriloid. This virilization draws them nearer to the boisterous masculine puberty stage. In the normal state of feminine puberty there is only a quiet and simple transition from one age to another for it simply means the gliding gently, from a suave and promissory femininity, to a strong fulfilment of perfect womanhood. But it is always unmistakably feminine throughout. On the other hand, the male passes through an intersexual stage with a strong feminoid coloring, to a robust masculinity; the leap is long, the reaction strong, the perturbation deep. The little female he carried within him falls asleep gradually to give place to the brutish-energetic awakening and outstretching of the male.

(b) *Disease:*—We concur with Henry Claude and his disciples when they agree upon the existence of two different diseases which break out during the juvenile age: dementia praecox and schizophrenia. The former is the extinguishing of a candlelight whilst the latter is the kindling of a light. In the former the intellect dies out; in the latter it awakens but in a disorganized form. According to them we thus have the following schematic process:—

A. *Dementia praecox:* (Primitive or semi-primitive dementia, but always rapid). Incurable by definition, with possible remissions.

B. (1) *Schizoidea* (by Kretschmer, which for Bumke and Berze would only be an attenuated schizophrenia). It would always require a psychopathic constitution, i.e., the schizoid predisposition.

(2) *Schizomania* (If there exists also an accentuated hereditary load and, or, a toxic-infectious factor). It may be periodical or continuous with unadaptability to environment. This would be the potential schizophrenia described by Bleuler.

(3) *Schizophrenia* (Mental Derangement): The difference which they established (Claude and Robin), most acutely, consisted in that

the dementia praecox individual (quite confirmed) has no great mental problems, *they have no thoughts;* the *schizophreniac has thoughts, but these are dislocated.* These authors anesthetized their patients with ether, but not deeply, thus penetrating into their mental world. In the schizophreniac there would appear to exist a disturbance or disorder in the thinking and behavior processes, which would seem to be due to a functional dissociation or disjunction judging by the discording characteristics: movable, changeable, capricious and its evolution more or less cyclical. These are revealed by an autistic type of delirious activity. It would appear to be in reality a discordance between intellectual and pragmatic activity, under the influence of an affective complex. This latter causes Minkowsky to separate the demential deficit in dementia praecox from that which he terms *"pragmatic déficit"*. "The discording factors"—he adds—"are clearly differentiated from true dementia." "The real schizophreniac" —he asserts—"loses vital contact with reality without his sensitive motor-apparatus, without his memory, without his very intelligence becoming impaired".

Summing up this line of thought, which is that which we exposed for the first time in this very Society many years ago, in collaboration with Dr. Nerio Rojas, and (personally) in two publications last year * I might add, modifying and enlarging the old Esquirol aphorism by comparing human intelligence with wealth, thus:—

The idiot always was a man of poverty.

The dementia praecox subject is an impoverished wealthy man.

The schizophreniac is still a wealthy man but spends his money unwisely, disorderly.

So as not to confuse them again, I should like to make absolutely clear the evolutionary stages, in accordance with the foregoing. We would thus have, in a practically definite picture, the following:—

1. Schizotimic temperament.
2. Schizoid constitution (Kretschmer).
3. Schizomania (Claude).
4. Schizotimia.
5. Schizophrenia:
    a) Continuous or chronic (may have remissions).
    b) Intermittent (outbreaks).
    c) Dementia (terminal or catastrophic).

Schizoid constitution: Some authors have classified this state un-

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der the same category as that constitution which makes the *introverts* by Jung; the "asintonie" by Minkowsky and Bleuler.

This would be the constitutional basis upon which later is construed the perfect schizophrenic edifice. But, we must not forget that it refers to degenerative types who carry genotypically accentuated factors of disharmony.

They are all *poly-constitutional,* with a constitution acting as *Chief of Group* which here is the *Schizoid.* Each patient, however, also colors his own disease, with brushes on second planes of the other constitutions, i.e., paranoid, mythomaniac, asthenic, depressive-maniac, perversion, hyper-emotive constitutions.

There is thus a psychopathic constitution: the *schizoid constitution,* which the dementia praecox subject does not have and need not have.

Kretschmer maintains that schizoid subjects have a surface and a depth; upon the surface we find: "sharp & cutting brutality, gross insensibility, irony, mollusc timidness, imperceptibly escaping. Or the surface is a void (null), and we are confronted by an individual who appears before us as an interrogation mark; we sense something insipid, boring and yet problematic". But, what is behind that mask? "There are schizoide subjects—adds Kretschmer—with whom we may have lived for 10 years without daring to assert that we know them". Bleuler called this inner life autism. In reality the true formula of this underground existence is: egocentrism, egophilia, egoism. "It is during the age of puberty—according to the Master of Marburg—that the schizoide pecularities attain their major development", but, it cannot be said which it is, the disease, or an outbreak of disease, "for the normal pubescent emotions have a great affinity with the features of the schizoide temperament, i.e., shyness, dullness, uncouthness, sentimentality, pathetic hypertension."

The somatic constitution which accompanies this temperamental indecision is another physical indecision: the leptosomic constitution. Its notion, according to Kretschmer, includes, with the asthenics, "the great mass of their bodies, dry and muscular, endowed partly with a great vitality and perfect power of resistance, capable of multiple achievements in sports". The current formula would thus be:—"narrow body, narrow face, sharp-pointed nose", which in its extreme form is the *asthenic* subject.

Sexuality:—In the past of all schizophrenic patients we find an abnormal sexuality. Be it precocious and prolonged masturbation, homosexuality, perversions of all kinds, above all a vivid and energetic incestuous tendency. They create, during the illness, complexes

which color delirious ideas, hallucinatory and interpretative. Kretschmer before us already noted this and asserted that "in studying carefully our schizoide subjects we immediately find amongst them individuals whose genital instinct is directed towards ambiguous, abnormal courses," and he explains this by their constitutional "affective frigidness, above all, and spasmodic thirst for excitations". At bottom, their polyhedral degeneration with perversion of all the instincts.

Many authors have outlined sufficiently the great syndromes: i.e., autism, ambivalence, mental disgregation. I wish to insist upon several less profound but objective manifestations. For example: *on the mask of the schizophrenic patient*—at times it is impressive to watch the fixedness, the rigidity on the faces of these patients, but we must not confuse them with the parkinsonian rigid fixedness nor with the stuporous or catatonic patients' expression. There is upon their faces as if it were a fixed expression of fear, as if they were confronting something unpleasant or dreadful which has already taken place or which they anticipate and dread. Sometimes it is their position in face of reality, in the estimation of values which casts that uncertainty into that fixed and vacant stare, in that semi-ritual seriousness which at times also resembles an expression of surprise. A patient once confessed to me that sometimes she seemed to be detached from her environment, from the reality of *others,* and as if *floating* in space.

It is interesting to confirm that the narcissism of the schizophrenic subject nearly always leads to the first symptoms of the disease being of a hypochondriacal nature. They stand permanent watch over their physical state, their thoughts, their reactions, their feelings; everything others do is invariably interpreted by them as being injurious to themselves. They believe all things fall upon them. These patients are not detached from reality: they are badly joined. They are not completely *disconnected* as we commonly and accurately call it, but they confront a hostile reality; they fear it; they contradict it, they suspect it aggressive and *struggle against it,* defending their "Erlebnis", their own wishes, their freedom to live in the fulfilment of their unrestrained instinct without the social blockade.

They take into account their environment but do not value it as do the sane. They see the environment in the same manner as the pubescent during his *puberty crisis:* in rebellion. But that which in puberty satisfied their instinct they continue to long for without being able to satisfy it in the present reality which is allied to their fortified *super-ego.* We might say they have two stories which endeavor

to confound each other, to superpose one another on a single plane of time and space. The impossibility of achieving this is what creates the conflict. One cannot be at one and the same time with God and the Devil, though one may desire it. The schizophrenic subject would like to live in fiction but within reality; a reality diffused in the thick atmosphere of smoke of their fiction (creation). As if he wished that the castle of smoke of his past or of his fantasy were reality and at the same time *were not reality*. Never were all the ambivalences more present than here. Hence, there arises also that uncertainty in face of these innumerable antagonistic "pairs".

In their behavior they are also contradictory and of unsuspected and surprising reactions; they commit foolish suicidal attempts, quite symbolic and inadequate. Their uncertainty causes their indecision. Through ambivalences practically in the same unity of time, they no sooner resolve to commit suicide when they immediately change their mind and remain in the middle of its fulfilment. They are uncertain whether or not to commit suicide. They are impulsive, *sudden* in all things. In general, they do or say incongruities through lack of continuity in their intellectual process of maturity of judgment. They are guided more by impulses borne on sudden desires or from unexpected ideas which suddenly cross through their brains like meteors. Thus, they propose or initiate organizations, activities, studies, careers, societies, voyages, systems, changes of life, which no sooner have been commenced than they are abandoned, sometimes after merely outlining the plan of these projects. Their flight from the reality of their environment is also due to the same mechanism of intellectual process; they long for something they know not what. They do not have the discretion to hide their disease. Generally, the systematic "delirante" *is worthy* of being, if a male, a self-respecting gentleman; if a female, a *refined and discreet lady*. They are usually refined, irreproachable; they present no useless or easy breaches upon their delirious brow as does the schizophrenic subject. This is due to their lack of mental maturity, to the absence of unity in functions, some more developed than others. There are too many: *perhaps; who knows, I don't know, maybe, why?, what for?, I think there is something wrong, they don't think well of me; if there is something let them say so; they can't fool me, I wish to leave, "I wish" and "I do not wish";* and the enormous Ego always present like some stone giant forever interposing himself in the path of their happiness.

EVOLUTION

In regard to the progress of the disease, we have already seen it in the scheme. There may appear one or several outbreaks; or remain in a continuous and prolonged state, or it may be intermittent; it may become chronic, with remissions, or it may end up (after a lengthy passage of time, or catastrophically) in dementia.

Of course, Bleuler only refers to this disease (not to dementia praecox) in the chapter in which he erroneously includes both entities, when he says: "the disease progresses chronically or with relapses; in all periods it may come to a standstill or recede somewhat, but probably there is no *'restitutio ad intergrum'*."

Undoubtedly, there are patients who remain in what is called by some authors: *"a post-psychotic condition,"* characterized by a certain fragility or by a definite nervous disequilibrium. But, as we have already stated, in the schizophrenic patient there is a lack of complete maturity, and, as if it were, a permanent state of puberty which is the *schizoid constitution* and which may be termed a sort of *pubescent constitution* or permanent puberty. Thus it remains, it being a psychopathic constitution, as an abnormal character: a certain puerility, a state of continual estrangement, egocentrism with narcissism, suspicion of environment, vanity and humility, longings, imageries, fantasies, etc. And as—once past their puberty—they live more in the past than in the present, hence their tendency to regressive forms. They cannot *altogether grasp the present,* and, moreover, when they are again *disconnected* through some new outbreak of the disease. Then, the past is once more present and the conflict which had been thought removed or solved appears again. A past which is real or transformed or feared or believed, desired but never superated. In order to make him abandon his puberty stage the patient would have to lose his schizoid constitution.

My esteemed colleagues: I do not know if I have succeeded in giving a clear exposition of this thesis, decidedly and continually dualistic in face of the dementia praecox and schizophrenia. Dementia praecox is a condition, by definition, incurable and progressive. Schizophrenia is a functional disease which may or may not end in dementia. It is, therefore, curable.

It is well worth while, therefore, to sharpen our clinical sense to endeavor not to confuse, as we did at the beginning of our practice, and include all or nearly all juvenile psychopathic conditions under the heading of dementia praecox.

I therefore advise to set aside definitely that tendency still in

existence which divides schizophrenia (confusing it with dementia praecox) in its clinical forms as follows:—simple, catatonic, paranoid and hebephrenic forms. Real schizophrenia does not assume such clinical forms. There is only schizophrenia in different grades.

In this manner we shall have gone a long way towards the grasping of this new entity which is, precisely, that which was the cause of contradictory opinions on the part of Regis at the Kraepelinian Unicato, i.e., dementia which is curable and which is therefore not dementia; the pathologic group which, according to Serbsky, would have the fundamental characteristic of being a step towards dementia and which, usually ends favorably; "there would thus be dementia without dementia"—the classical hare stew without the hare.

Moreover, we must not forget that the schizophrenic subject more than any other patient is a *field, an organic history, a vital history.*

The psychosomatic is, thus, half fate and half the marching of Time. That time which in its transit makes us, as the jurist thinks, acquire rights or lose them.

The constitutional psychosomatic ground of the schizoid subject is watered by that gardener, good or perverse, which is called Life. The flower that shall spring from this soil will, to a great extent, depend upon that factor.

BUENOS AIRES,
ARGENTINA

PSYCHODRAMA FOR MENTAL HOSPITALS, PART II

NATHAN S. KLINE, M. D.

Veterans Administration Hospital, Lyons, N. J.

MARRIAGE AND CHILDREN

(Situation Three)

The question as to whether a man who has been in a mental hospital should get married, and if he does so, whether he should or should not have children, has risen so frequently that it was thought wise to present this problem to the patients themselves. This situation is closely concerned with fear of relapse and also with the possibility of inheritance of mental instability. Although, as always, it is emphasized that each patient must work out his own solution—another possibility is interjected in this specific situation by suggesting a psychiatrist as a third, impartial and informed authority who may be appealed to in case of doubt.

A

(For unmarried patients)

Properties:

On one side of the stage are seating accommodations for two, and on the other, a desk and other properties to suggest a psychiatrist's office.

Dramatis Personae:

1. The Patient.
2. His Girl Friend.
3. The Psychiatrist.

Structure:

Place: The girl friend's home.

Time: Approximately two months after the patient's discharge.

Action: The patient's girl friend gets him to review his accomplishments in his two months since discharge and brings up a discussion of their former plans to be married in the near future. She may mention the fact that she has found an apartment which will be available within the next few weeks, and that it might be a good idea to get married, since they may not be able to find a place to live by themselves again in the near future. Her method of getting

the patient to "pop the question" would, of course, depend on her own personality. If the patient does not bring up the question of the effect of his mental hospitalization on their marriage the girl friend brings it up when she has "trapped" the patient into proposing. She should then draw the patient out on what effect he believes the mental disease he has gone through will have on his marital adjustment. She should attempt to lead the situation to an impasse which is solved by having either the patient or the girl friend, preferably the patient, suggest a visit to a psychiatrist to discuss the matter thoroughly. The action then shifts to the other side of the stage where one of the staff physicians plays the role of the psychiatrist in his office and the problem is then presented to him for discussion.

B

(For married patients)

Properties:

Accommodations for four. Refreshments or other props that make for realism may be added for a scene in which two friends drop in for a short visit with the patient and his wife.

Dramatis Personae:

1. The Patient.
2. His Wife.
3. His Friend.
4. The Friend's Wife.

Structure:

Place: The patient's home.

Time: Approximately a year after the patient's discharge from the hospital.

Action: A friend of the patient and his wife have dropped in to return a book and are on their way to a dinner engagement. The patient's wife offers them a drink, or other refreshments, and they sit down for a few minutes. The friends mention the "latest cute remarks" or other doings of their youngest child and discuss the joys of parenthood. The visitors necessarily leave soon, since they are going to a dinner engagement and serve merely to introduce the subject of parenthood in a casual and realistic manner. After the friends leave, the patient's wife brings up the subject of their having children and after gaining the patient's acquiescence or enthusiasm endeavors to get him to raise the problem of inheritance of mental disease and the desirability of children for those who have suffered from mental disorder. If the patient does not bring up this objec-

tion (as in the previous scene) the wife does so herself. The views of the patient are extracted and the services of the psychiatrist suggested when no solid solution can be reached. The action again shifts to the psychiatrist's office and the problem is presented to him.

Moderation:

1. Other patients are solicited for their comments on the problem.
2. The patient is then asked to criticize his own performance.
3. The general problem of "Marriage and Mental Disease" is brought up for discussion if it has not already been emphasized.
4. The staff psychiatrist is asked to discuss the reason for the comment which he has made in the drama.
5. The moderator then inquires as to whether any of the group has a specific problem of this sort to meet and if they do, urges them to act out the problem.

Discussion:

This situation not only serves to correct prevalent misconceptions about mental disease, but suggests to the patient the role of the psychiatrist outside the hospital as an interested and informed authority who can help in meeting difficult problems instead of merely an individual who is of use only after the situation "has gotten out of hand".

INQUISITIVE NEIGHBORS

(Situation Four)

The public at large has such interest in mental hospitals that the patient is inevitably going to be subjected, directly or indirectly, to frequent inquiries as to what actually takes place in such an institution. Recent "exposés" in Cosmopolitan and Life Magazines, newspaper stories, radio dramatization, and such books as "The Snake Pit" have whetted the public appetite and resulted in such a series of contradictions that invariably the patient will be asked for the "low-down". In order to prepare the patient for a situation which is bound to cause at least some anxiety the present psychodrama is used. Often this leads to a discussion of the treatment in mental hospitals as a broader topic since there is no effort made to avoid so-called group therapy with any of the situations as a point of departure.

Properties:

None needed.

Dramatis Personae:

1. The Patient.
2. A Friend, about the same age as the patient.
3. The Friend's Mother.

Structure:

Place: On the sidewalk, Sunday morning after church. (Actually, any locale could be used for this particular scene; a grocery store, a train, etc.)

Time: A few weeks after the patient's discharge.

Action: The friend and his mother are standing on the corner when they see coming down the street, the patient. Reference is made to the fact that he has been at "the bug house" at Lyons and the two of them speculate as to what really happens at a mental hospital. The patient joins the group and after a short discussion of neutral subjects such as the weather, the friend's mother leaps in "feet first" to question the patient about his hospitalization. The patient's friend tries to take the sharp edge off her questions but indicates in a more subtle manner that he too would like to know what really happened. We have found it valuable to refer to specific statements made in magazines, books, or on the radio to try and have the friend's mother create as unpleasant an impression as possible with frequent references to beatings of the patients, inadequate food and clothing, "strait jackets", etc. The patient's friend, on the other hand, inquires about the nature of electric and insulin shock therapy, "truth serum" (intravenous sodium amytal or pentothal), occupational and other types of therapy, etc.

Moderation:

1. Other patients are asked to comment on the situation.
2. The patient is asked to criticize his own description of the hospital and the handling of the inquisitive friends.
3. The patient's friend and the friend's mother are asked to comment on the adequacy of the patient's replies.
4. A general discussion is held as to the attitude of the public towards mental hospitals and towards former patients.
5. Any patient who thinks he may have difficulty in meeting this sort of questioning is given the opportunity of "working through" the situation.

Discussion:

The attitude of the patient toward his treatment and his ability to handle this type of questioning are both important for him. A correct attitude on his part can do much to correct many popular

misconceptions. Means of improving mental hospital care almost always arises as a subject for discussion and the psychiatrist as well as the patient can learn a good deal. Although most of the men are appreciative of the treatment they have received it must be pointed out to them that general public support is necessary and that they, as patients, are better informed than almost anyone else of the need for public and especially legislative support to bring about those improvements they have to suggest.

VETERANS' RIGHTS AND BENEFITS

(Situation Five)

The previous method of using semi-structured situations is abandoned during the present "drama" period which is specifically for use in a Veterans Administration Hospital. One of the representatives from the "Contact Office" gives a short resumé of what the mentally hospitalized veteran is entitled to when he leaves the hospital. This is followed by a question period. Following this the Vocational Adviser discusses his function and advises the veteran what he may expect when he applies to the U. S. Employment Service as many of our veterans will. At the conclusion of his talk there is often a question period which is followed by a "drama" during which one of the patients applies for work at the U. S. Employment Service.

A. Contact Office Representative.
B: Vocational Adviser.
C: U.S.E.S. Application.

Properties:

A desk and two chairs. Other props can be added for realism as is convenient.

Dramatis Personae:

1. The Patient.
2. The Interviewer at the U.S.E.S. Office.

Structure:

Place: Office of the U. S. Employment Service.

Time: Within a week or two of the patient's discharge.

Action: The patient registers for unemployment insurance and makes inquiries about potential jobs.

Moderation:

1. The other patients are asked to criticize the drama.
2. The limitations of mentally handicapped veterans are discussed, if this has not already been done.

3. There is a detailed discussion as to whether the particular patient has fully utilized his opportunities, both in the hospital and outside.

4. The vocational adviser is asked to criticize the patient's application from the point of view of the U.S.E.S.

5. The patient is asked to criticize his own performance.

6. The question as to the advisability of having definite "post-hospital" plans is brought up for discussion.

"IN-LAW" PROBLEM

(Situation Six)

The current housing shortage is unquestionably one of the great contributing factors in a large number of mental disorders. Men returning from Service have a definite problem of adjustment to make with their wives and the necessity, in many cases, of living with "in-laws" complicates the situation beyond the possibility of a solution. When this particular problem must be faced by a veteran who has also been hospitalized for a mental disorder, unless some preparation is made, the situation may very likely have traumatic effects. If the patient has a general idea of how he intends to deal with a situation and is given an opportunity of "acting it out" in advance, his anxiety may be somewhat alleviated when the actual problem does come.

Properties:

On one side of the stage are chairs for three and a desk and on the other side comfortable seating accommodations for four.

Dramatis Personae:

1. The Patient.
2. His Wife.
3. A Real Estate Agent.
4. The Patient's Father-in-law.
5. The Patient's Mother-in-law.

Structure:

Place: The first part of the scene is in a real estate agent's office and the second part is in the home of the patient's "in-laws".

Action: The patient and his wife go to a real estate agent, a former acquaintance of the patient, in an effort to find an apartment or house in which to live. The agent comments on the current housing situation and implies either by words or actions, the current practice of accepting bribes to find living space. He then attempts

to sell the veteran a home at a greatly inflated value under the G.I. Bill. If he does convince the veteran that he should buy a home under the Bill the drama is temporarily interrupted to discuss the possible pit-falls in purchasing property at greatly inflated values by pointing out that the property cannot be simply dropped since certain permanent obligations are incurred. The drama is then continued under the assumption that the veteran and his wife cannot find a place of their own in which to live, but must, at least temporarily, live with his wife's family. The situation then shifts to an after-dinner setting at the home of his wife's parents where her mother inquires how they made out in looking for a place to live. They relate their story. The "in-laws" apartment is such that it is necessary for the patient and his wife to pass through her parents' bedroom in order to get to their own. The patient's father-in-law must get up for work at 4:30 or 5:00 every morning and therefore likes to be in bed by a little after nine. At first he insists that the patient and his wife, if they are to live with them, must be home by nine every night and cannot entertain their friends in the home since they would have to pass through the parents' bedroom. The mother-in-law may suggest a re-arrangement of the rooms or urge the father-in-law to be more lenient about the hour of arrival at home. The details are relatively unimportant, but what is important is that a compromise is worked out in which both the patient and his in-laws must give up, in part, their original position.

Moderation:

1. The other patients are called upon to comment on the drama.
2. The "in-laws" are asked to discuss both their own and the patient's attitude and position.
3. The patient is asked to criticize his own handling of the situation.
4. The need for temporary compromise, not only in this situation, but in many other situations, is discussed.

Discussion:

Here the veteran is brought face-to-face with a problem which he likely may have to face upon leaving the hospital. If he is aware of the existence of the housing shortage and the actual extent of it, he may be better prepared to meet it. This situation is of value not only to those who will face this particular problem but illustrates the general need for temporary compromises that every man must face.

THE SICK COUSIN

(Situation Seven)

The degree of "insight" which a recovered mental patient has, varies very greatly from individual to individual. There can be little question, however, that a certain minimum of understanding of what has happened to him is highly desirable. In the course of psychodrama no systematic attempt is made to develop anything resembling complete insight but constant stress is placed on the fact that all the men did have mental disorders (or emotional ones), that hospitalization was necessary or at least desirable, and that their ideas or emotions have changed in some ways since the time of their admission. In the present drama the patient is given a chance to evaluate his own symptomatology at the time of his admission and to discuss certain aspects of his own case when it is presented in a slightly disguised form. Often this brings forth material which could not be gotten so long as it referred to the man personally without the stipulation that the case is that of a "third person".

Properties:

1. Comfortable seating accommodations for two. Other props can be added for realism as convenient.

Dramatis Personae:

1. The Patient.
2. The Patient's Friend.
3. The Friend's Cousin.

Structure:

Place: The patient's home or office.

Time: Approximately ten years after the patient's discharge from the hospital.

Action: The patient is told that he has now been discharged from the hospital about ten years and is a "pillar" of the local community. His success, both economic and personal, has won the respect of all his acquaintances and neighbors. A friend of the patient who knows that the patient was once at a mental hospital, therefore turns to him for advice when a cousin begins showing mental symptoms. He drops into the office or home of the patient and requests that he talk to the cousin and advise the family what to do. He describes rather explicitly the behavior of the cousin which closely resembles that of the patient prior to his admission to the hospital. We have found it desirable to disguise the case history to some degree, e.g., if one of the patient's presenting symptoms was somatic complaints, a differ-

ent site of localization is chosen. If the patient attempted suicide by slashing his wrists we have the cousin attempting suicide by turning on the gas, etc. The patient's friend then brings in his cousin and leaves him, with the promise to return shortly. The cousin then adopts an attitude similar to that which the patient formerly had; paranoid, depressed or euphoric, and assumes most of the patient's symptoms. After the patient has interviewed the cousin to his satisfaction, the friend returns and the cousin leaves. The patient and his friend then discuss the cousin's case in respect to etiology, treatment, and prognosis.

Moderation:

1. The other patients are asked to comment on the drama.
2. The patients are encouraged to also discuss the etiology, treatment, and prognosis of the cousin.
3. The patient is then asked to comment on both the cousin's behavior and his own advice.
4. Both the patient's friend and cousin are asked to discuss the patient's performance.
5. If the patient choses to make known to the group that this is really his own case the value of "insight" is discussed.

Discussion:

This thinly veiled presentation of the patient's own case history enables him to make comments which he would otherwise not feel "safe" to indulge in. No effort is made to have the patient reveal to the group that this is his own case history although most patients do so. In this manner the patient is enabled to obtain a certain perspective which he otherwise might not be able to achieve. However, we have often found that this situation meets with such great interest that after the presentation of the regular series of situations an extra session is held so that all members of the group are given the opportunity of working through the "sick cousin" set-up.

REJECTING FATHER

(Situation Eight)

In reality this situation is an attempt to deal with the Oedipus complex. Since too much resistance would be met if the situation were presented in its pristine form, the father is presented as a definitely unkind and inconsiderate individual, objectively as well as subjectively, which lessens to some degree the guilt feelings which inevitably arise. Depending upon the ability of the group, the situation can be worked through at either a superficial level with an effort to

achieve primarily "emotional understanding" rather than intellectual realization of the dynamics or, in certain groups, the theory and universality of the situation can be emphasized. Although relatively few of the men actually in fact have "rejecting fathers" the intense interest which this particular drama holds for all the men indicates that we are dealing with more than appears on the surface.

Properties:

1. Seating accommodations for three. Other props can be added for realism.

Dramatis Personae:

1. The Patient.
2. His Father.
3. His Mother.

Structure:

Place: The patient's home.

Time: A few weeks after the patient is discharged.

Action: The patient is told that prior to his hospitalization he had been working with his father. We attempt to leave the man in his occupation of choice to make the situation more realistic, e.g., if he worked in a factory his father was the foreman; if he worked in an office, his father was the manager or the department head, etc. The father begins the scene by questioning the patient as to what he intends to do now that he has been discharged from the hospital. He implies that he believes that the patient has been "faking" and also states that if the patient had led a "respectable" life he would not have landed in a mental hospital. He probes around until he finds a tender spot in the patient's defences and proceeds to dig into him at this point. The mother, in the meantime, attempts to mollify the father and to protect the patient and defend him. The "needling" is climaxed by the father's statement that other men at the plant or office have been making remarks about the patient and kidding the father with the result that the father does not want the patient to return or be associated with him in any way. The father then demands that the patient immediately and on the spot make plans that will involve as little association with the father as possible and also implies or states that it would be highly desirable if the patient did not live at home. The mother continues to favor the patient in the discussion without actually coming into conflict with the father. The patient is forced into a decision at which time the drama is ended.

Moderation:

1. The other patients are asked to comment on the drama.
2. Contrary to the usual procedure we have found it best not to ask for comments from the other "actors" in the drama.
3. The patient is asked to comment on his own performance.
4. The discussion is thrown open as to the role of the father in general, the depth of discussion depending on the members of the group.
5. Patients with special "father problems" are asked to act through the scene.

Discussion:

This manner of presenting the Oedipus situation makes it highly realistic and removes the "panic edge" by presenting a father who, in fact, deserves more hatred than love. A basis for intellectual discussion is presented but the primary emphasis is placed on working through the "emotional situation".

For many years the trend in psychotherapy has been to lay stress on intra-psychic problems. This has been done at times almost to the exclusion of consideration of extra-psychic problems. Within the past few years there has been recognition of the importance of this aspect of treatment and psychodrama in the manner it is here used is a powerful instrument for that purpose.

Since psychodrama is a form of group therapy it naturally partakes of the potent socializing influence of that type of therapy. Its aim however, is not merely adjustment within the "group", nor even in the hospital primarily, but preparation for adjustment in the community—which is the acid test.

The situations any single patient is likely to meet will vary considerably but at any one hospital a selection of situations can be made, the majority of which any one patient is likely to encounter.

With certain patients psychodrama has been used in conjunction with other types of group therapy but it has also been used independently.

RESULTS

At the time of this writing we have been using psychodrama for only a year so that a full evaluation cannot be made. The moderator has received several letters from former participants in the drama who have either commented thankfully upon the fact they did not attempt the solution to one of these psychodramatic problems which they first tried in the sessions and found even there to

be inadequate. Another asserted that "getting that job was a snap" after having had the preparation of a rather complete "grilling" in Situation One psychodrama.

At present an attempt is underway to more soundly evaluate the benefits of this procedure. Instead of taking all patients who are deemed suitable for psychodrama the men are paired as to duration of illness, prognosis, and social situation and then only one of each pair attends the psychodrama sessions—the other being used as a control. Arrangements have been made to do a follow-up study one year after discharge in order to compare the social adaptability, remission rate, etc., of the test and control groups.

SUMMARY

1. The use of psychodrama as a pre-discharge "socializing" therapy is stressed.
2. The need for such a procedure and the relative simplicity with which it can be carried out are emphasized.
3. The mechanics of organizing such sessions are discussed in some detail.
4. The eight situations selected for use at the Veterans Administration Hospital, Lyons, New Jersey, are explored in considerable detail. These include (a) Quest for a Job, (b) The Overprotective Mother (and the role of the Social Service Worker), (c) Marriage and Children, (d) Inquisitive Neighbors, (e) Veteran's Rights and Benefits, (f) The "In-law" Problem, (g) The Sick Cousin (in which the patient has a chance to discuss his own case objectively), (h) The Rejecting Father.
5. Note is made of the favorable results obtained to date and the experimental method of evaluation now being used is delineated.

LYONS, N. J.

Gratitude is expressed to Philip Goldberg of the Psychology Department of the V. A. Hospital, Lyons, N. J., for his assistance in planning the overall project and to Miss Emily Scanlan and Miss Ellen Dixon of the Social Service Department and American Red Cross, respectively, for their cooperation. Particular acknowledgment is made to Mrs. Edward Smith and Mrs. Arthur Herrmann (volunteer workers) and Mr. Timothy Farrell for their enthusiastic participation as "Dramatis Personae".

A STUDY OF NEGRO AND WHITE DISCIPLINE CASES IN THE WESTERN STATE PENITENTIARY OF PENNSYLVANIA

Part I

BY HAROLD R. MALAMUD, B.S., M.S.[1]

I. INTRODUCTION

The treatment of the discipline problem within institutions thus far has been concerned almost entirely with the type of infractions committed and the resulting disciplinary measures. Little or no effort has been extended towards an attempt to segregate or classify the probable discipline from the nondiscipline case upon entry to the institution. The most recent work on this phase of the problem has been that of Hanks.[1] A study by Horsch and Davis [2] in which the probable discipline cases were rated as to personality traits indicates an allied field of recent inquiry.

The present study was directed primarily toward the problem of ascertaining what differences, if any, on the basis of available data, existed between those inmates who were reported for infractions of rules in the penitentiary (discipline cases) and those who were not reported (nondiscipline cases).

II. SOURCES OF DATA AND PROCEDURE

Selected for the present study were all cases committed to the Western State Penitentiary of Pennsylvania during a period of one year, commencing with Jan. 1, 1930, and extending through Dec. 31, 1930. Each case was followed through the entire period of incarceration from records on file in the psychology and parole departments.

Of an original 624 commitments during the year 1930, 605 cases remained for the purpose of initial study. Exclusions totaling 19 cases consisted of mental cases transferred to other institutions, prisoners transferred for administrative purposes; female prisoners sent to the prison for women; 1 case of attempted suicide with no previous or subsequent history of infractions and 1 case in which the only infraction was committed within thirty days after being

1. The present study was made under the supervision of Dr. G. I. Giardini, former Psychologist of the Western State Penitentiary of Pennsylvania now Superintendent, Parole Supervision, Pennsylvania Board of Parole.

received at the penitentiary, involving a breach of rules (an institutional offense).

Of 20 cases in which there was an isolated charge of breach of regulations, only 1 case existed in which such a breach of regulations occurred within one month of commitment. The remaining 19 committed such breaches of regulations from one to four years after arrival at the penitentiary, thus allowing sufficient time to have become acquainted with the rules of the institution. It would appear that inmates were given ample warning by the guards, if they were committing minor infractions, before being reported for violations and resulting disciplinary action.

Table I presents a gross analysis of the entire population treated

TABLE I

INCIDENCE OF PROBLEM AND CONTROL CASES AMONG NATIONALITIES RECEIVED DURING 1930

	Problem			Control		
Nationality	N	Per Cent of Own Group	Per Cent of Total Commitments	N	Per Cent of Own Group	Per Cent of Total Commitments
Native White	156	40.52	25.79	229	59.48	37.85
Negro	91	60.27	15.04	60	39.73	9.92
Italian	8	34.78	1.32	15	65.22	2.48
Austrian Hungarian	4	33.33	.66	8	66.67	1.32
All Others	9	26.47	1.49	25	73.53	4.13
Totals	268		44.30	337		55.70

herein; problem cases being separated from control cases. Of the 605 cases, 44.30 per cent or 268 cases required some form of disciplinary treatment. Sixty per cent of the Negro cases required disciplining as compared to 40 per cent of the native whites.

In order to secure a sufficient number of cases permitting of valid comparisons and results, the present study confined itself to dealing with native white and Negro inmates; all other nationality groups were eliminated due to lack of sufficient cases. However, in the remaining portion of this study no comparisons are made between Negro and white inmates, both groups being considered as one. This problem will be presented in a later study, now in the process of preparation. The combined native white and Negro groups comprise a total of 429 cases: 214 disciplinary cases and 215 control or nondiscipline cases within the age range of 16 to 34 years.

Throughout this study the terms "problem" and "control" are used. The following definitions are applicable to these terms. Those cases having disciplinary reports issued against them are considered discipline or problem cases. Those cases not receiving disciplinary reports are considered nondiscipline or control cases.

III. APPLICATION OF MEASURES TO CONSTANT AGE GROUPS OF PROBLEM AND CONTROL CASES

A. *Age of Inmates*

In order to determine the effect of age upon adjustment in the institution, the study group of combined Negro and white inmates was divided into three age classifications as presented in table II.

TABLE II

AGE OF PROBLEM AND CONTROL INMATES WHEN RECEIVED AT WESTERN STATE PENITENTIARY

	Problem			Control		
Age Groups	Frequency	Cumulative Frequency	Per Cent	Frequency	Cumulative Frequency	Per Cent
16–21.9	69	69	32.24	53	53	24.65
22–27.9	96	165	44.86	94	147	43.72
28–33.9	49	214	22.90	68	215	31.63
Totals			100.00			100.00

The largest group in both problem and control categories consisted of those inmates whose ages were from 22 to 27.9 years. The mean age of the problem group was 24.44; probable error 0.25; standard deviation 5.35; while the mean age of the control group was 25.42; probable error 0.21; standard deviation of 4.48.

There have been two common beliefs regarding disciplinary cases arising within a prison: (1) that the younger men will become disciplinary problems due to their not having had, in most cases, previous experience within an institution such as a penitentiary; (2) conversely, that the younger men will not become discipline cases due to their ability to adjust more easily and quickly to routine life. While there is no significant difference between the mean ages of the problem and control groups as indicated by a critical ratio of 0.06, it is to be noted that more of the youngest age group and fewer

of the oldest age group were reported as problem cases. These results are corroborated in the recent study by Hanks.[1]

B. *Intelligence*

Intelligence did not act as a factor in distinguishing between the problem and control groups. Both groups, inclusive of all ages, were within the upper limits of the borderline group as defined by Terman's classification. Table III discloses the means, probable

TABLE III
MEANS AND STANDARD DEVIATIONS OF STANFORD-BINET INTELLIGENCE QUOTIENTS FOR PROBLEM AND CONTROL AGE GROUPS

Age Groups	Problem				Control				
	N	M	PE_m	SD	N	M	PE_m	SD	CR
16–21.9	69	79.49	1.12	13.81	52	80.77	1.31	14.05	.74
22–27.9	96	81.67	1.34	19.38	93	79.73	1.10	15.77	1.12
28–33.9	49	76.63	1.50	15.56	66	76.36	1.34	16.11	.18
All Ages	214	80.33	.72	15.73	215	79.41	.72	15.45	.90

error of means, standard deviations of Intelligence Quotients and the critical ratios existing between like ages as well as the critical ratio between the problem and control groups within the entire age range treated. As can be seen from the above table no significant differences on the basis of intelligence were secured. Hanks [1] found similar results, i.e., that no significant difference existed on the basis of intelligence between his discipline and control groups.

Sutherland [3] states that of the deficient borderline cases admitted to Auburn in 1921, 29.57 per cent were punished. Assuming that his deficient borderline classification is comparable to the borderline classification of the present study, we found that of 94 cases definitely within the limits of the borderline classification 41.5 per cent received reports.

C. *Previous Incarcerations*

It has been the tendency in the handling of prison inmates to assume that an inmate who has run the gamut of institutional life, from juvenile detention home to penitentiary, would have become accustomed to prison regulations or as often expressed would have become "prison wise". The hardened prisoner has been depicted as a chronic recidivist who looks upon his internment as an interlude between crimes. He views imprisonment as an unfortunate break in his career and is anxious to secure his release. Such a person is expected to be on best behavior for he realizes that it is

the "good boy" who gets the most consideration when parole time is at hand. We would, therefore, expect the individual with the most incarcerations, one who is truly a chronic recidivist, to be the best behaved while in the institution. This opinion is exemplified in the work of Zerk and Singleton,[4] who claim that the recidivistic prisoner with an abnormal personality conforms to prison because he is "prison wise". These authors feel that such prisoners realize it is the easiest way to get along and they therefore obey the rules. The logic of this reasoning is not hard to follow. However, this is not the conclusion reached in the present study. On the contrary prisoners who were older and who had more previous incarcerations were the violators of prison regulations. The youngest age group of both problem and control categories show no appreciable difference when compared on the basis of previous incarcerations. The reason for this is readily realized due to their not having had sufficient time to engage in careers of crime.

In an attempt to secure some indication of the number of previous convictions which tended to produce a greater percentage of problem cases, the cases having no previous incarcerations were combined with those having one previous incarceration. Table IV disclosed that the combined intervals of no previous conviction and one previous conviction produced 42.4 per cent as problem cases. Of those inmates having two or more previous convictions, 66.4 per cent

TABLE IV

PER CENT OF PROBLEM CASES ON BASIS OF PREVIOUS CONVICTIONS

Previous Incarcerations	Number of Problem Cases	Number of Control Cases	Per Cent of Problem Cases	Critical Ratio
0	76	101	42.4	....
1	49	69	....	....
2	35	27	....	....
3	22	13	....	....
4	16	2	....	7.06
5	5	1	....	....
6	5	1	....	....
7	3	1	....	....
8	1	...	66.4	....
9	0	...	....	....
10	1	...	....	....
11	0	...	....	....
12	0	...	....	....
13	0	...	....	....
14	1	...	....	....
TOTALS	214	215		

were problem cases. That a true difference existed is indicated by a critical ratio of 7.06.

In all but the youngest age group (16-21.9 years) the difference between problem and control groups of like ages was significant, critical ratios being well above 5. Disregarding age groups and comparing all problem cases with all control cases, a critical ratio of 7.59 was secured indicating that the problem group was made up of inmates having significantly more previous incarcerations.

D. *Per Cent of Time Incarcerated*

This index corroborates the results obtained in the above discussion. It indicates the total time which an inmate has been confined within institutions since the time of first conviction. The index is computed in the following manner, as set forth by Gorsuch: "The total time incarcerated since the first conviction is divided by the total time elapsing between the first and last convictions, and the quotient multiplied by 100".[5] From the index of "Previous Incarcerations", we should surmise that the groups having the greater number of previous incarcerations would have spent a greater amount of time within institutions. This expectation is fulfilled.

An interesting item disclosed was that, while an increase in age was accompanied, in the main, by an increase in the per cent of time incarcerated in the problem group, the opposite trend took place in the control group. An increase in age in the control group was accompanied by a decrease in the per cent of time incarcerated. This lead to the conclusion that the older inmate who had spent a lesser amount of time confined did not require disciplinary treatment. The older inmate who had been incarcerated for a greater period of time was the problem case. We found the greatest number of problem cases, on the basis of "per cent of time incarcerated", within the age group of 22 to 27.9 years. The inmate who spent a greater amount of time within institutions and who was within the ages of 22 to 27.9 years was the individual who required disciplining.

By referring to table V which compares the age groups of the problem and control categories in order to determine the statistical reliability of the difference between the two, we found that while all differences were in favor of the problem group it was not significant in the youngest age group, was definitely significant in the age group of 22 to 27.9 years as indicated by a critical ratio of 4.02 and approached a significant difference in the oldest age group by virtue of a critical ratio of 2.88. We may assume, then, that this measure which indicates the length of time served in various institutions in the

life of the criminal to be a reliable indicator of the probability of the need for discipline.

E. *Mean Seriousness of Past Offenses*

This measure was adapted from the study by Gorsuch [5] in which the author assigned numerical values to offenses. In distributing our cases on the basis of mean values, we found that two dominant inter-

TABLE V

MEANS AND STANDARD DEVIATIONS OF PER CENT OF TIME INCARCERATED [1] FOR PROBLEM AND CONTROL AGE GROUPS

Age Groups	Problem				Control				
	N	M	PE_m	SD	N	M	PE_m	SD	CR
16–21.9	68	25.00	2.49	30.41	53	22.08	3.00	32.44	.75
22–27.9	96	29.90	2.03	29.53	92	19.02	1.78	25.36	4.02
28–33.9	44	25.68	2.71	26.66	65	16.00	1.98	23.65	2.88
All Ages	208	27.40	1.37	29.34	210	18.86	1.26	26.99	4.59

1. Time calculated from date of first incarceration.

vals prevailed: The one interval included such cases as Forgery and Counterfeiting, Assault, Embezzlement, Fraud, Robbery, Burglary and Rape. However our cases were by a great majority those of robbery and burglary. The other dominant interval included cases involved in Larceny, Sodomy and Narcotic Law Violation. Again, the great majority of our cases in this interval were larceny charges. In explanation of the accumulation of cases in these two intervals we quote Reckless, "It was found that in America only seven types of

TABLE VI

MEANS AND STANDARD DEVIATIONS OF MEAN SERIOUSNESS VALUES OF PAST OFFENSES FOR PROBLEM AND CONTROL INMATES

Age Groups	Problem				Control				
	N	M	PE_m	SD	N	M	PE_m	SD	CR
16–21.9	69	1.98	.12	1.46	53	1.45	.14	1.46	2.94
22–27.9	96	2.01	.10	1.38	94	1.78	.10	1.45	1.65
28–33.9	47	2.13	.12	1.27	65	1.96	.12	1.43	.98
All Ages	212	1.96	.06	1.39	212	1.64	.07	1.45	3.65

offenses consistently become known to the police. They are felonious homicide, rape, robbery, aggravated assault, burglary (breaking and entering), larceny (theft), and auto theft".[6]

From the means set forth in table VI can be discerned this fact:

That with an increase in the age of the inmate there is an increase in the seriousness of the offenses. The problem group has a higher mean seriousness per age group than the control group. However with the exception of the youngest age group the difference is not significant.

F. *Seriousness Index of Present Incarceration*

This measure, again adapted from Gorsuch [5] indicates the seriousness of the offense for which the inmate was sent to the Western

TABLE VII

MEANS AND STANDARD DEVIATIONS OF SERIOUSNESS INDICES FOR PROBLEM AND CONTROL INMATES

Age Groups	Problem				Control				
	N	M	PE_m	SD	N	M	PE_m	SD	CR
16–21.9	69	3.57	.06	.68	53	3.32	.06	.52	2.94
22–27.9	94	3.46	.04	.51	94	3.34	.02	.35	2.64
28–33.9	47	3.54	.06	.66	68	3.30	.04	.54	2.98
All Ages	210	3.53	.03	.63	215	3.30	.02	.47	7.09

State Penitentiary of Pennsylvania. Our interest was to determine whether or not the crime most recently committed served to set apart the discipline from the nondiscipline case. Again there was a definite grouping within the interval embracing two of the most frequently occurring violations labeled as "robbery" and "burglary". Here again we found that the problem case had, on the whole, committed a more serious crime than the control case. When we compared the problem group against the control group, disregarding ages, the problem group was found to have had a greater seriousness value, as indicated by the critical ration of 7.09. (See Table VII.)

G. *Minimum Sentence of Inmates*

Of psychologic importance in the study of discipline is the following question: Is the prisoner's behavior in the institution affected by the length of sentence imposed by the court? We have, in the State of Pennsylvania, an indeterminate sentence with a minimum and maximum imposed by the court. The maximum amount of time which the prisoner may have had to serve was ignored in this study due to the realization that almost without exception the inmate recognizes only one limit of his imprisonment. That limit is the minimum time imposed upon him by the court.

Contrary to Hanks' [1] statement that the length of sentence did

not offer a means of distinguishing between the discipline and non-discipline cases, we found that the amount of time to be served may have an effect upon the behavior of the inmate. Our control group consisted of those individuals having relatively short sentences, the average minimum time being approximately thirty-six to thirty-seven months. Conversely, the problem group consisted of those individuals having a decidedly longer period of time to spend within the institution, the average minimum time approaching eighty-three months.

As expected and as showed in table VIII reliable differences existed between the problem and control classifications of approximately the same ages. Critical ratios in favor of the disciplined groups being above 6. in each age group lend support, statistically, to differences first recognized through inspection. These results indicate that the individual who drew a longer term tended to be among the problem cases, while the inmate who had a term of from six months to three years minimum time was less apt to come to the attention of the disciplinarian.

It is interesting to point out in connection with the present meas-

TABLE VIII

MEANS AND STANDARD DEVIATIONS OF MINIMUM SENTENCES GIVEN[1] FOR PRESENT CONVICTIONS OF PROBLEM AND CONTROL INMATES

Age Groups	Problem				Control				
	N	M	PE_m	SD	N	M	PE_m	SD	CR
16–21.9	61	86.35	6.52	75.60	51	36.94	2.46	25.99	7.08
22–27.9	95	81.89	6.75	97.61	94	36.50	1.77	25.46	6.50
28–33.9	46	82.97	6.71	67.49	67	39.22	2.73	33.12	6.04
All Ages	202	83.52	4.04	85.13	212	37.46	1.30	28.15	10.85

1. Minimum term of sentence given by courts: viz., in a sentence of 2 to 4 years, minimum time of 2 years taken. All "lifers" excluded from above table.

ure that the age of the prisoner, as it may affect his adaptability or nonadaptability within the prison, is not a factor when considering probable discipline cases on the basis of minimum sentence. We found that the young inmate between the ages of 16 to 21.9 years who had a long minimum sentence became a problem case just as the older inmate did with an equal amount of time to serve.

H. *Time Served in Present Incarceration*

On the basis of the preceding measure of "Minimum Sentence" we would expect to find that inmates who actually served a longer

period of time tended to become problem cases. The present index fulfills this expectation.

In the present measure time served was computed from date of admittance to date of release in full months, fifteen days or over being considered a full month. Lifers were excluded due to the inability of predicting behavior for the balance of the term remaining to be served at the time this study was made. Also excluded from the present measure were those cases not yet released on minimum terms, as well as those held over minimum terms who had not received their release at the time of this study.

Table IX discloses that the problem group in the two lower age groups served more than twice the length of time served by corre-

TABLE IX

MEANS AND STANDARD DEVIATIONS FOR TIME SERVED[1] IN PRESENT INCARCERATION OF PROBLEM AND CONTROL INMATES

Age Groups	Problem				Control				
	N	M	PE_m	SD	N	M	PE_m	SD	CR
16–21.9	62	67.74	2.44	28.50	49	30.00	1.80	18.62	12.44
22–27.9	95	66.00	2.16	32.24	92	32.74	1.34	18.98	13.09
28–33.9	46	71.48	2.83	28.50	63	27.83	1.44	16.99	13.82
All Ages	203	67.66	1.39	29.42	204	29.88	.85	18.06	23.13

1. Only those inmates who completed their terms of incarceration included.

sponding age groups of the control category, while in the oldest age group the problem cases served almost three times that served by the control group.

The results of this measure indicate that the problem cases served more time than the control cases; critical ratios being well above 12 in each age group.

IV. SUMMARY AND CONCLUSIONS

The present study indicates that on the basis of the measures used, marked differences existed between the problem and control inmates within the Western State Penitentiary of Pennsylvania. (1) Intelligence did not operate in differentiating the two groups; the mean intelligence of both groups ranging in the upper borderline category as defined by Terman. (2) No difference existed between the two groups on the basis of age although more problem cases came from the group between 16 and 22 years of age. Fewer problem cases came from inmates in the age group of 28 to 34 years of age.

(3) The prisoner who was older and with a greater number of previous incarcerations was more frequently found among the problem cases. (4) The problem group was composed of inmates who had spent a greater per cent of time and a greater number of months within the confines of institutions since their first conviction. The older prisoner who had been incarcerated less than the prisoner of a like age with a long record did not become a problem case. (5) The inmate with a greater seriousness value of past offenses, just as the inmate presently imprisoned for a more serious crime was more likely to be a discipline case. (6) The minimum sentence imposed is definitely reliable in differentiating between the discipline and nondiscipline cases. The control group had a shorter sentence than the problem group. On the other hand, the problem group had a greater length of time in which to be reported for infractions. (7) As in the measure of "Minimum Sentence", the time served in the present incarceration set off the group reliably. The control group was made up of individuals having, relatively speaking, short term sentences.

Summarizing, we may say that the inmate in this particular institution, who had the greater number of previous convictions, that had spent a greater portion of his time in prison since his first conviction, that had been charged with the more serious offenses, and had been given the longer sentences, was more apt to be the problem case while in the institution. These findings are contrary to the common belief that the recidivist, being "prison wise", does not get into trouble while in prison. The present study shows that recidivism, and long experience in penal institutions are more often prognostic of misconduct in prison.

PART II

I. INTRODUCTION

The first part of this study [1] dealt with the study of discipline as against nondiscipline cases at the Western State Penitentiary of Pennsylvania without regard to race. This section of the study attempts to satisfy the question as to whether there is a significant difference between the Whites and Negroes in so far as their probability of becoming problem cases to the management of the institution. Specifically, we are interested in whether the Negro or the White need be given special attention when confined in prison.

II. SOURCES OF DATA AND PROCEDURE

Selected for the present study were all Native Negro and White cases committed to the Western State Penitentiary of Pennsylvania during the year commencing with Jan. 1, 1930 and extending through Dec. 31, 1930. Each case was followed through the entire period of incarceration from records on file in the psychology and parole departments. After excluding certain cases involving the insane, female prisoners and others which could not be considered as appropriate cases for study, a total of 74 Negro and 140 White discipline cases and 43 Negro and 172 White nondiscipline cases within the age range of 16 to 34 years remained for study. While we admit that the range is large and in one instance, at least, the number of cases relatively small, yet, we feel that the cases are of a sufficient number and the range of years close enough to permit statistical study with valid results.

III. APPLICATION OF MEASURES TO NEGRO AND WHITE PROBLEM AND CONTROL INMATES

A. *Incidence of Problem Cases*

Of 605 commitments selected for our initial duty (See Part I, Table I) 60 per cent of the Negro cases required disciplining as compared to 40 per cent of the Whites. The Negro group had 1.49 times as many problem cases as the White group, based on population and coefficients of frequency.

Of the 117 Negro and 312 White cases considered in this part of the study 63.2 per cent of the Negroes required disciplining as compared to 44.9 per cent of the Whites.

B. *Age of Negro and White Inmates*

Results of this study indicated that the Negro problem group had a larger number of individuals within the age interval of 29 to 33.9 years than did the White group in the same age interval. There was a smaller percentage of younger Negroes within the problem group than within the White group. The young White inmate, according to our distribution, was more apt to become the discipline case. Conversely, the older Negro tended to need more attention than the older White inmate. While this difference existed in problem cases it did not exist when comparing the Negroes and the Whites of the nondiscipline or control cases.

Table I discloses the following pertinent facts when comparing Negro problem group vs. White problem group and White problem group vs. White control group. The Negro problem case was significantly older than his White companion as indicated by a critical ratio of 5.83. The white problem case was younger than the Negro

TABLE I

MEANS AND STANDARD DEVIATIONS OF AGE OF PROBLEM AND CONTROL NEGRO AND WHITE INMATES WHEN RECEIVED AT WESTERN STATE PENITENTIARY

Race	Problem				Control				
	N	M	PE_m	SD	N	M	PE_m	SD	CR
Negro	74	26.05	.35	4.45	43	25.56	.48	4.63	.83
White	140	23.59	.24	4.16	172	25.38	.23	4.44	5.45
CR		5.83				.33			

problem control case as well as being younger than the White control case.

C. *Intelligence of Negro and White Inmates*

Intelligence as related to discipline was a relatively nonoperative factor in distinguishing between the problem and control classifications. Although the White and Negro problem cases have a higher average intelligence quotient than the White and Negro control cases, the difference is not statistically significant. However, as may be expected, a substantial difference does exist between Negro and White within the problem group and the Negro and White within

TABLE II

MEANS AND STANDARD DEVIATIONS OF STANFORD-BINET INTELLIGENCE QUOTIENTS FOR PROBLEM AND CONTROL NEGRO AND WHITE INMATES

Race	Problem				Control				
	N	M	PE_m	SD	N	M	PE_m	SD	CR
Negro	74	73.78	1.21	15.42	40	70.50	1.45	13.59	1.76
White	140	83.79	.84	14.76	171	81.49	.78	15.12	2.00
CR		6.80				6.79			

the control group in favor of the White groups. Table II illustrates these differences and similarities very plainly, not only by inspection, but by the statistically reliable critical ratios obtained on the one hand and the nonsignificant differences existing on the other.

D. *Previous Incarcerations*

This factor of recidivism differentiates the White from the Negro and also the problem cases from the controls. The Negro inmate has a longer record of recidivism than the White as shown in table III. But when we compare Negroes and Whites with the same number of convictions, 54.3 per cent of the Negroes with two convictions or less were problem cases, whereas 42 per cent of the Whites with two convictions or less were problem cases. When we compare

TABLE III

PER CENT OF PROBLEM CASES ON BASIS OF PREVIOUS INCARCERATIONS

Previous Incarcerations	Negro Problem Cases	Negro Control Cases	Per cent of Problem Cases	CR	White Problem Cases	White Control Cases	Per cent of Problem Cases	CR
0	20	14	....	....	56	87	....	....
1	12	18	54.3	....	37	51	42.0	....
2	12	5	....	....	23	22	....	....
3	12	4	....	....	10	9	....	....
4	10	1	....	5.27	6	1	....	4.41
5	3	..	.....	....	2	1	66.7	....
6	3	1	....	....	2	..	....	....
7	..	..	....	....	3	1	....	....
8	..	..	....	....	1	..	....	....
9	..	..	....	....	..	..	....	....
10	1	..	83.3	....	..	..	....	....
11	..	..	....	....	..	..	....	....
12	..	..	....	....	..	..	....	....
13	..	..	....	....	..	..	....	....
14	1	..	....	....	..	..	....	....
TOTALS	74	43			140	172		

Negroes and Whites with three convictions or more, we find a still higher incidence of problem cases among the Negroes than among the Whites. Table III further shows that the Negro control group is somewhat less recidivistic than the White control group.

Twenty-nine per cent of all Negro inmates were first offenders as compared with 45.8 per cent of all White inmates. The Negro and White inmate who required disciplining was more recidivistic. The Negro of the problem group was significantly more recidivistic than the White of the problem group.

E. *Per Cent of Time Incarcerated*

This index adapted from Gorsuch's [5] study indicates the total time which an inmate has been confined within institutions since the

time of his first conviction. While the preceding measure of "Previous Incarcerations" produced a significant difference in the comparison of Negro and White (problem) cases, the present measure did not result in such a difference. While a significant difference or an approach to significance did not exist between the Negroes and Whites within the problem and control groups, a statistically reliable difference existed by comparing the problem against the control groups in each race. Reference to table IV substantiates this statement by virtue of critical ratios derived and presented therein; that both Negroes and Whites who had spent a greater portion of time within institutions were most likely to be included among the problem cases.

TABLE IV

MEANS AND STANDARD DEVIATIONS OF PER CENT OF TIME INCARCERATED[1] FOR PROBLEM AND CONTROL NEGRO AND WHITE INMATES

RACE	PROBLEM				CONTROL				
	N	M	PE_m	SD	N	M	PE_m	SD	CR
Negro	71	30.42	2.30	28.80	42	30.95	2.64	25.34	3.00
White	137	25.84	1.70	29.49	168	18.33	1.42	27.36	3.39
CR		1.70				.87			

1. Time calculated from date of first incarceration.

A greater percentage of problem cases, Negro and White, came from inmates who had spent from 35 to 100 per cent of their time incarcerated since their first conviction.

A significant difference was not obtained when comparing Negro and White problem cases secured from cases having served up to 34.9 per cent of their time incarcerated. A significant difference was obtained when we compared Negroes and Whites who served from 35 to 100 per cent of their time incarcerated showing that the Negroes produced more problem cases than White serving a like time; critical ratio 3.72.

F. *Months Incarcerated*

This index is the third of a group of three measures, viz., previous incarcerations, per cent of time incarcerated and months incarcerated, which attempts to illustrate the possibility of discerning probably discipline from nondiscipline cases on the basis of past record. We have seen that the inmate who has had a greater per cent of time incarcerated tends to become the problem case. The total number of months which an inmate has served indicated reli-

ably the possibility of such an individual becoming a problem to those controlling the institution. A significant difference existed between the Negro and White inmate in the problem category, the Negro of the problem group having served more months incarcerated. (See table V). No significant difference existed between the Negro and

TABLE V

MEANS AND STANDARD DEVIATIONS OF TOTAL MONTHS INCARCERATED[1] FOR PROBLEM AND CONTROL NEGRO AND WHITE INMATES

Race	Problem				Control				
	N	M	PE_m	SD	N	M	PE_m	SD	CR
Negro	71	26.62	2.52	31.48	42	14.05	1.93	18.53	3.96
White	138	16.16	1.30	22.60	170	9.24	.83	16.10	4.49
CR		3.69					2.29		

1. Computed from date of first incarceration.

White of control cases. In a comparison of the Negro problem case with the Negro control case and the White problem case with the White control case, uncontestable evidence, as indicated by critical ratios of 4. and above, is presented attesting to the recidivistic record of problem cases.

Of all Negro cases who had been previously incarcerated for fifteen months or less, 57 per cent were problem cases as compared to 39

TABLE VI

MEANS AND STANDARD DEVIATIONS OF MEAN SERIOUSNESS VALUES OF PAST OFFENSES OF PROBLEM AND CONTROL NEGRO AND WHITE INMATES

Race	Problem				Control				
	N	M	PE_m	SD	N	M	PE_m	SD	CR
Negro	73	1.95	.10	1.28	43	1.78	.13	1.26	1.06
White	139	1.97	.08	1.44	169	1.56	.08	1.46	3.66
CR		.16				1.47			

per cent of Whites in the same category. That this was a true difference is indicated by a critical ratio of 3.81. No significant difference was obtained between Negroes and Whites previously incarcerated for fifteen months or more.

G. *Mean Seriousness of Past Offenses*

This measure adapted from the study by Gorsuch[5] in which the author assigned numerical values to offenses. After computing

values for each case, it was determined, as indicated in Table VI that very little difference existed between the racial groups in the problem and control categories. The only reliable difference was obtained between the White problem and White control group; critical ratio in favor of the White problem group of 3.66. Thus the White problem cases had a greater seriousness value for past crimes than did the White control cases.

H. *Seriousness Index of Present Incarceration*

In this measure the offense for which the individual was sent to the penitentiary was assigned a value originally computed by Gorsuch.[5] We are interested, primarily, in whether a difference existed between Negro and White offender on the basis of the seriousness of the crime which brought the individual into confinement.

A reliable difference was found between the White and Negroes

TABLE VII

MEANS AND STANDARD DEVIATIONS OF SERIOUSNESS INDICES FOR CRIMES CAUSING PRESENT INCARCERATION OF PROBLEM AND CONTROL NEGRO AND WHITE INMATES

RACE	PROBLEM				CONTROL				
	N	M	PE_m	SD	N	M	PE_m	SD	CR
Negro	73	3.69	.06	.75	43	3.46	.06	.57	2.71
White	137	3.44	.03	.50	172	3.26	.02	.44	5.00
CR		3.73				3.17			

showing a higher seriousness of crime index for the latter, in both the problem and control group. But the Negro problem group had an even higher index than Negro control group. As shown in table VII, we found that the Negro and White inmate who had committed a more serious crime were more apt to require disciplinary treatment than would the Negro and White inmate who had committed a less serious crime.

It is interesting to note that our White inmates were more frequently involved with minor felonies such as carrying deadly weapons, nonsupport and so-forth; while our Negro inmates had a greater percentage of their group involved in the act of homicide.

I. *Minimum Sentence of Inmates*

Although Pennsylvania uses an indeterminate sentence setting both minimum and maximum confinement periods, the maximum sentence for each inmate was ignored for the purpose of this study.

What difference exists between Negro and White inmate as to their behavior on the basis of their reaction to the length of sentence imposed by the court? Will a longer sentence tend to produce a discipline or problem case? If so, or if not, does the Negro inmate react differently than the White inmate? We found that race was not a

TABLE VIII

MEANS AND STANDARD DEVIATIONS OF MINIMUM SENTENCES GIVEN[1] FOR PRESENT CONVICTIONS OF PROBLEM AND CONTROL NEGRO AND WHITE INMATES

Race	Problem				Control				
	N	M	PE_m	SD	N	M	PE_m	SD	CR
Negro	67	89.02	6.50	78.84	42	44.57	3.98	38.23	5.83
White	138	80.81	5.11	87.96	172	35.86	1.35	26.09	8.51
CR		.99					2.07		

1. Minimum term of sentence given by courts; viz., in a sentence of 2 to 4 years, minimum time of 2 years taken. All "lifers" excluded from above table.

factor in the present measure. While there was no reliable difference between the Negro and White in the problem group, there was a significant difference between White and Negro of the problem group and White and Negro of the control group. In both races the problem group had received longer minimum sentences. Our conclusion, then, is that the inmate who had a longer minimum sentence became the problem case, regardless of race. (See table VIII).

J. *Time Served in Present Incarceration*

We were not able to reliably differentiate between the White and Negro discipline case on the basis of time served in the present incarceration. This fact may be pointed out; as illustrated in table IX, that in a comparison of Negro and White of the problem group

TABLE IX

MEANS AND STANDARD DEVIATIONS OF TIME SERVED[1] IN PRESENT INCARCERATION OF PROBLEM AND CONTROL NEGRO AND WHITE INMATES

Race	Problem				Control				
	N	M	PE_m	SD	N	M	PE_m	SD	CR
Negro	68	72.53	2.46	30.10	38	28.10	1.33	12.17	15.87
White	135	64.31	1.68	28.88	166	30.29	1.00	19.13	15.51
CR		2.76				1.13			

1. Only those inmates who completed their terms of incarceration included.

against Negro and White of the control group, statistically reliable differences in favor of the problem cases (either race) were found. Critical ratios obtained were in excess of 15. Thus a difference exists between the problem and control groups of each racial group, but not between the racial groups themselves. The inmates serving the longest time will tend to become the problem cases of the institution. However, it is possible that the problem cases became problem cases due to their having had more opportunity to commit infractions by virtue of having had longer periods of time to spend within the institution.

III. SUMMARY AND CONCLUSIONS

The Negro inmate in the Western State Penitentiary is more apt to be a problem than the White inmate. The problem Negro is significantly older than the White inmate generally, but is about the same age as the Negro and White control groups. The Negro inmate is significantly of lower IQ than the White, but the Negro problem case is on the average slightly more intelligent than the Negro control case. The Negro inmate was considerably more recidivistic than the White. When comparing Negroes and Whites with an equal number of previous incarcerations we found a larger proportion of problem cases among the Negroes. While the Negro inmate spent a longer portion of time in prison than the White, the difference was not statistically significant. Comparing the two racial groups on the basis of the number of months served in prison, we found a more significant difference in favor of the Negro, both in problem and control groups. On the whole, it does not appear that the Negro inmates commit more serious crimes than the White unless we limit ourselves to consideration of the crime for which the cases under discussion were serving time. The findings show that the Negroes were in for the more serious crimes. On the other hand, the Negro inmate was not given a longer minimum sentence than the White, nor was he required to serve longer than the White before released.

If we compare the Negro problem group with the Negro control group, we find the problem Negro to be of about the same age, slightly more intelligent, considerably more recidivistic than the control case. The problem case spent significantly more time in prison, did not commit any more serious offenses, but was given a significantly longer sentence for the present offense, and served a considerably longer time for it.

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THE SOCIAL STRUCTURE OF A CRIMINAL UNIT OF A PSYCHIATRIC HOSPITAL * **

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The literature on the behavior of the criminal insane patient is rather scanty in comparison with other fields in psychiatry. There also is considerable misconception as to what actually takes place, on a day-to-day basis, in a hospital for patients in this category. It is with these thoughts in mind that a simple discussion or description of the behavior of a group of this sort seems to be in order. We will lay particular stress on the interpersonal relationships which spontaneously emerge. This subject, as far as we know, has not been presented from the point of view of criminal insane psychiatry. It is our hope that a later date we may expand or amplify some of the thoughts presented briefly in this paper.

First, a short summary of the source of our patients, the charges against them, and a description of the facilities available are presented:

The male criminal psychotics of the state of Maryland are segregated at Spring Grove State Hospital in Baltimore. The average number of patients is 65. These men come to the hospital from three sources: (1) any county court in the state, or Baltimore City court, may send a man for treatment or observation; (2) any mental illness which develops in a prisoner in a state penal institution is treated here; (3) a few patients are transferred from the civil portion of the hospital because, for one reason or another, they have proved to be too incorrigible. (These latter are, of course, not criminals strictly speaking, but their offenses are usually sufficient to have constituted a criminal act if committed outside a hospital.)

The seriousness of the offense is immaterial. If, after arrest, a man is found to be mentally ill he is referred to us. Therefore, the charges vary from vagrancy to murder. The psychiatric diagnoses are just as varied.[1] The hospital has prison status in that each

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** This paper will also appear in the *Handbook of Correctional Medicine*, Philosophical Library.

[1] The following is a breakdown of the charges against the present group of patients. In some cases conviction has been obtained and sentence imposed, in many commitment prior to trial was made.

Murder—16; manslaughter—2; assault with intent to kill—6; burglary—3; rape—8; larceny—6; robbery—4; vagrancy—2; arson—2.

One offender on each of the following charges: malicious destruction of property; incorrigible minor; nonsupport; sodomy; false fire alarm; disturbing the peace; resisting an officer.

Civil cases without criminal charge—10.

day spent there counts on the patient's sentence, if any, and the duration of hospitalization is taken into consideration if a patient is tried and sentenced subsequent to discharge. This is helpful from a morale point of view.

As for facilities, we, along with a majority of hospitals, have felt the current pinch. Additions and corrections and a hoped-for new building have all, of necessity, been tabled due to wartime shortages of labor and materials. The present setup consists of a separate building, considerably isolated from the rest of the hospital, which contains two floors, or wards. These wards house 25 and 35 patients respectively. Each ward has its own dining room, dormitory and recreation room. There are also twelve isolation or seclusion rooms. The basement occupational therapy department has not been used for some time because of lack of attendants. Because of the legal angle, the patients are continuously under lock and key. Ground parole or special privileges are impossible. These facts are enumerated, not in a critical sense, but merely to show how little we have to offer the patient from a physical standpoint. However, with the present chronic shortage of trained personnel, it is doubtful if a more elaborate setup could be utilized if it were available.

There is considerable patient turnover. With the census remaining around 65, there are one or two admissions a week. Thus, patients of all ages, from 17 to 75, and in all stages of recovery and deterioration are lumped together. This is of necessity and is unfortunate, but it does present a psychiatric melting pot the bubbling and occasional boiling of which is a rich experience to watch.

Particularly in the lay mind, the conception of crime and a psychosis in the same individual seems difficult. The expectation is that this must be a very hard group with which to deal. This belief undoubtedly stems, at least in part, from the fact that it includes a considerable number of men who all their lives have shown asocial and antisocial behavior, long before their psychotic days. However, it is equally true that it also includes many who have committed their first offense, and this, from the history, is directly attributable to the development of a mental illness.

Be that as it may, good or bad as far as their past history is concerned, the fact is that a very high percentage level off and make an adjustment to ward life and association with the other patients.

Almost all of the patients have had a period in jail prior to admission. Unfortunately, this period is usually two or three weeks, occasionally longer. During this time, if the patient has been disturbed or particularly hostile about his circumstances, he usually has

been in isolation and restrained by means of handcuffs or a straitjacket. As a result he is frequently unnecessarily upset upon arrival. Nevertheless, unless he is actually combative, he is told that he is starting with a clean slate and is put directly on the ward. This may seem a waste of breath with a psychotic patient and occasionally it is, but usually the greater freedom in comparison with his former circumstances, and the calmness with which he is received by the other patients has a sedative effect. The newness of the entire situation probably has somewhat the same result. Gradually he finds his comfortable place, as the bubble in a carpenter's level, and, unless he is too preoccupied by his illness, in the course of time is in a group around the radio, doing jig-saw puzzles or in one of the several card games.

Of the 60 admissions in the past year only 2 are now in isolation:

One is a 30 year old paranoid schizophrenic who brutally beat his brother-in-law to death with a hammer. He has been in the hospital about six months and his only thought concerning the crime is that he should have done it sooner. His inability to get along on the ward is due to his feeling that certain patients resemble his victim and he has an uncontrollable compulsion to attack them.

The other is a 25 year old mentally defective, almost blind man with a massive elephantiasis of his lower right leg. He is going through a schizophrenic-like reaction, is very disturbed and tears off his clothing. However, he is improving and will probably be out of seclusion soon. He is serving ten years for burglary, and has only been in the hospital for two months.

The above description of a patient's adjustment is greatly simplified. While this is primarily a spontaneous reaction it is influenced by many external factors. We do not pretend to know them all, but a few may be enumerated. With some, the fact that they are locked up under the watchful eyes of attendants and associating with obviously psychotic men has a sobering effect. This applies particularly to the psychopaths, alcoholics, and some mental defectives. (Patients in this group are sent to us because frequently their behavior is superficially difficult to distinguish from that of psychotic patients.) The relatively philosophic attitude of a majority of the patients and a realization on the part of the newcomer that they are "all in the same boat" is helpful. Frequently the other patients will put an unruly man in his place in self defense. The concerted statement on the part of several that he'd "better pipe down or else" works at times when the efforts of attendants and physician have failed.

Some patients become tolerable ward patients only as a result of specific therapy. Examples of this are:

A 41 year old paretic was admitted about five months ago with a minor larceny charge committed while drinking. He had a history of having worked for fifteen years on one job, but six months prior to admission he gave this up and worked successively in three breweries. Upon admission, he was irritable, complaining, loud, argumentative and very dogmatic. After a course of malaria and continuing chemotherapy, he has gradually become cooperative, quiet, almost timid (much like his normal self according to his wife) and a good worker. He is now in charge of one of the patient dining rooms.

Another patient is a 24 year old Navy dischargee who was irritable, sullen, and very difficult. He was found to be subject to nightmares during which he would rise in bed shouting at the top of his voice. Suspicion of epilepsy and a therapeutic test with luminal not only eliminated the episodes but thus far has made him a much more agreeable patient.

Psychotherapy is helpful in the adjustment of some. However, many, in fact most, have adapted themselves on a day-to-day basis some time before individual interviews are practical. Of course, a kindly, patient, understanding attitude, mixed with firmness when indicated, from the time of admission is a form of psychotherapy and is vitally important.

Some patients find religion an aid in becoming more comfortable with themselves and their environment. A case in point is that of a 35 year old mental defective whose weakness for arson makes institutional care a necessity. He was continuously full of physical complaints and a nuisance to all around him. About six months ago he began to listen to a national religious hour on the radio. He wrote for literature and through this contact a local representative of the church came to visit him. Through his reading and periodic visits by "his" pastor he has been much happier and has not mentioned his complaints for weeks. Previous efforts to modify him had been unavailing.

A certain group of patients, instead of needing a period of adjustment to hospitalization, find it to be the answer to their problem. Getting away from their disturbing environment produces an almost overnight change. We see this particularly in the so-called prison psychosis—a psychotic episode developing in a person, usually without a previous psychotic history, while incarcerated in a penal institution. Why these men clear up so rapidly in an environment very like a prison and with fellow patients who frequently are former fellow prisoners is an interesting point for conjecture. We have one patient who over a period of years has been back and forth from

the penitentiary seven times. No matter how disturbed he is upon admission, in twenty-four hours he is ready to resume his old job in a patient dining-room. He is now eligible for parole but this cannot be granted while he is in the hospital and so far he has been unable to remain calm in prison long enough for a parole to be granted. This is an extreme case but there are others quite similar.

The value of experienced attendants in running a ward smoothly cannot be overestimated. The knowledge of when to loosen and when to tighten the disciplinary reins is not instinctive in many. In the main it is the product of training and experience. We have been fortunate in having a small nucleus of experienced men in our building. In fact, there have been many days when this small group has been all we have had and one man has had to handle an entire ward. (The normal complement is three men to a ward.) Yet, it can truthfully be said that under an able attendant the patients get along much better than under two or three new and inexperienced men. The difference can be felt just by walking into the ward. The air is tense, men are pacing the floor, some are sitting sullenly in a corner, and several come up to register complaints of real or imagined injustice. The new patients are not satisfied by the inexperienced attendant and the old patients try to take advantage of him.

If factors influencing patient adjustment and interpersonal relationships were being discussed in order of importance, time would probably head the list. Many patients adjust tolerably quite rapidly, but there is a small group which adjusts with great difficulty—here "time" is the only "answer". The schizophrenic or organic patient may be able to float on the ward only after deterioration has brought him to an almost vegetative level. The paranoid schizophrenic and the frequently manic may mellow with the passage of time. The unstable, immature, individual may "grow up" sufficiently to be able to get along.

An ordinary ward-walk reveals a rather tranquil sight. There are usually several card games in progress. Double pinochle is the favorite of several and it is a rather strange sight to see two schizophrenics, a psychopath and a mental defective enjoying a heated game. Rummy, casino and solitaire are also in evidence. Jigsaw puzzles are popular and a few are in almost constant use. Men are gathered around the radio. Some are reading comic books and popular magazines; mysteries find the most favor. Some are paired off in conversation and a half dozen or so in each ward are sitting, staring into space, oblivious of their surroundings.

In general, these little groups function as units independently of

the others. There is very little overlapping. Once a man has found his level, his friend or small group of friends, he is quite inclined to stick with it. This is true to a marked extent. A fight, a heated argument, or an acutely disturbed patient will usually be ignored or at most smiled at tolerantly by those not directly involved. The exception to the isolationism, as it were, is seen when a patient shows improvement. He then graduates to a more active, more alert group.

Usually the picking of companions and the formation of groups is done on an intellectual basis. That is, the mental defectives and the deteriorated patients pair off, and so on up the line; but this is not a constant finding. Some of the mental defectives who are relatively stable are leaders in the few group-activities possible; and, conversely, some of the more intelligent, because of their preoccupation and reduced psychomotor activity, are found below their expected level. Then there are some associations which superficially have no rhyme or reason. An example of this is the almost interminable card game enjoyed by a "burned-out" paretic and a fairly well-organized paranoid schizophrenic. It is felt that the Rorschach analysis may show a common denominator in the basic personalities of these seemingly mismatched people.

Quite a few of the men become specialists of a sort. This varies from really helpful work to merely ways of passing the time. One patient has a ward of twenty beds which he makes to a perfection which would be the envy of any nurse. This man is a defective deaf mute. Another, an old paranoid, rolls really fine cigarettes for almost the entire ward. A couple of the schizophrenics act as group stenographers in writing letters for those unable to write. Several of the patients weave baskets of willow which are very acceptable. One man claims he can put jig-saws together faster than anyone else in the building. Another spends his time fashioning intricate designs and models with paper and string. Still another makes himself very useful by his ability to do repair work on a sewing machine. At least half of the men are doing some work, in the dining room, making beds, polishing the floors or hardware, dusting or sweeping.

Just as the seriousness of the crime has no bearing on whether a man is sent to the hospital, so it has no bearing on his treatment in the hospital. The average attendant, coming and going as he does these days, has no idea of the crime committed by the individual patient. The patients are accepted as mentally ill men, not as criminals. It is our feeling that the mentally ill person who happens to commit a serious crime, even murder, in the course of his illness should not be punished, after he reaches a mental hospital, more severely than another person who had the same ideas but did not

actually do the deed. The sole criterion as to whether a man is allowed on the ward is his proved ability to adjust to ward life. If he fails at first, he is given repeated chances, until he does adjust if it is possible for him to do so.

It should be mentioned that the psychoses encountered are the same as in any mental hospital with the exception of true depressions. The relative absence of these is probably explainable on the basis of the lowered psychobiologic activity of the depressed not being conducive to the mental and physical exertion necessary for most crimes. About the only depressive reactions seen are in the transfers from penal institutions where the outlook of years of incarceration frequently is overwhelming.

From what has been stated thus far, it might seem that all is smooth sailing. This, of course, is not the case. Fights occur; plans for escape are formed and occasional attempts to escape are made. But these are not frequent and are obviously not peculiar to the criminal insane.

It is to be expected that acute psychotic episodes will occur. Experience soon shows which patients are most subject to these flare-ups and sufficient warning is usually given by the patient to allow for seclusion prior to physical violence. If warning of a blow-up is not present, or is missed, the violence when it comes is short-lived and since anything which might be used as a weapon is kept off the wards, serious damage is rare. Some of the patients invariably come to the aid of the attendants in quelling these disturbances regardless of whether the attack is on an attendant or a patient.

In some, these periods of disturbance are cyclic, occurring at fairly regular intervals and without apparent relationship to their environment. But in others, they are directly traceable to agitation by one or two individuals. In this the constitutional psychopath is the chief offender although an unstable defective or a hypomanic individual can be equally troublesome.

Many mental hospitals have no dealings with the full-fledged constitutional psychopath. In this they are indeed fortunate. Some have said that the psychopath, since he is not psychotic, usually is a good patient in an attempt to be discharged as soon as possible and continue his "career". This generalization is certainly not true in our experience. The psychopath is our greatest single cause of a disruption of the interpersonal relationship of the patients. Here are a few examples of the type of behavior encountered in such a man: he will take great delight in teasing and taunting a psychotic patient until he blows up; he will be the leader in planning escapes from the hospital, usually with one of his accomplices scheduled to

do the dirty work; he will be openly defiant about obeying orders, thus lowering the morale of the entire ward; he will turn "informer" and tell lies about the behavior and the plans of other patients; and he is full of talk of the legal aspects of the situation, The Bill of Rights, habeas corpus proceedings, etc., which starts a clamor for "our rights" among the other patients. It is our belief with the group under discussion that if psycopaths were not admitted many of the psychotic patients would be discharged much sooner.

Mental defectives have been mentioned frequently above and the question may arise as to why they are in a hospital with psychotic patients. Since they are sent to the hospital on court order, they have to leave by the same route. But here the legal definition of insanity enters the picture. Is this man able to tell right from wrong and act upon this knowledge? Is he able to comprehend the seriousness of his crime and defend himself in court? If the answer is in the negative, he stays with us because invariably he is too old for the state institution for defectives and there is no other place for him to go. This is a very unfortunate situation because the unstable defective is frequently a disturbing influence, and, in all fairness, it is not the proper place for him.

Considerable space has been devoted to the mental defective and the constitutional psychopath for two reasons. First, to point out their detrimental effect on the interpersonal relationships of this group and the feeling that they definitely do not belong in a hospital with psychotic patients. (We are referring to the defective and psychopath without psychosis. If they have a superimposed psychosis, that is a different matter.) Secondly, although we are philosophic about the present situation, we feel that there is no hope of future beneficial change unless these facts are repeatedly brought before the proper authorities until recognition of them is obtained and action taken.

By way of summary the following points seem pertinent:

(1) In spite of the wide divergence in ages and diagnoses, the average patient finds his level and makes a reasonably good adjustment with his fellow patients. Social groups form which help to stabilize the situation, here, as elsewhere.

(2) It is reasonable to assume that the interpersonal relationships would be improved if mental defectives and psychopaths were excluded. They do not logically belong in a hospital with psychotic patients.

A STUDY OF THE "ONLY CHILD" MALE OFFENDER IN THE NAVY*

H. ROBERT OTNESS (H-(S), U.S.N.R.)

INTRODUCTION

Since the days of Bohannon and G. Stanley Hall (1898) there have been many studies made on "only children" as well as on the possible effects of the order of birth on children with siblings. Psychologists have in part been challenged by Hall's statement that "being an only child is a disease in itself." Since that time on there have been spasmodic displays of interest in the problem either to confirm this statement or to refute it. The findings so far produced in research have resulted in divided opinions.

Some of the studies that have reported the "only child" to be inferior to the child with siblings are herewith mentioned briefly in a chronologic order: Bohanon (1898) (1) reported that "only children" were below average in school work; Friedjung (1911) (2) reported that 87 per cent of "only children" in his practice exhibited such behavior symptoms as fear, disturbed sleep, capriciousness, anorexia, enuresis and constipation whereas only 31 per cent of children with siblings showed these traits; Brill (1914) (3) from the psychoanalytic point of view emphasized the peculiarity of "only" and of last-born children because of parental solicitude and lack of competition; Burt (1925) (4) found that 12.2 per cent of "only children" were in his delinquent group and only 1.7 per cent in his nondelinquent group; Slawson (1926) (5) reported an undue large proportion of delinquents among the "only children"; Goodenough and Leahy (1927) (6) stated that they were more excitable and unstable; Busemann (1928) (7) reported "only children" to be below average in school work; Goodenough (1929) (8) found "only children" more distractable in mental test situations; Baker, Decker and Hill (1929) (9) also found a large proportion of delinquency among "only children"; Parsley (1933) (10) reported a high proportion of delinquency also; and another study reported in Breckenridge and Vincent (1943) (11) stated that "only children" men showed 5.72 times the average in the number of divorces while those who were middle children only 0.58 times the average. Also "only children" women showed 4.18 times the average in the number of divorces while the middle-children-women showed 0.65 times the average,

* The opinions or assertions contained therein are the private ones of the writer and are not to be construed as official or reflecting the views of the Navy Department or the Naval Service at large.

concluding that "only children" fail four to five times as often in marriage as the average of the population and that the middle children were better adapted.

Some other studies have found more hopeful conclusions including that of Blatz and Bolt (1927) (12) who stated that there were fewer misdemeanors among the "only children"; Worcester (1930) (13) reported that the "only children" were more intelligent, had better health habits and social traits and showed better academic achievement; Blonsky (1930) (14) reported results that agree with Worcester in part; Witty (1933) (15) from a study of 153 5 year old "only children" concluded they were somewhat superior in health, physical development, intelligence, and character traits.

A few studies that have reported no marked difference between "only children" and those with siblings include that of Fenton (1928) (16) reporting on public school children and college students that "only children" show fewer neurotic symptoms than the others; Ward (1930) (17) in comparing "only children" with children in three-child families found no marked difference in the kinds of maladjustments shown by the two groups; Walker (1934) (18) found no difference between the school achievement of 146 girls who were "only children" and that of the group of 527 girls of which they were a part.

This is not a complete list of the studies that have been made but it is a fair sample of the work that has been done to date and the trends in thought.

THE PRESENT INVESTIGATION

This study deals entirely with the male naval offender. It is a comparative analysis of: (a) 200 "only children" sailor offenders with 500 male naval offenders selected at random with respect to age, education, length of service and the number of offenses; (b) a comparative percentage analysis of the 200 "only children" with 1,000 unselected naval offenders with reference to factors of their naval history, family backgrounds, marital status, education, civilian delinquencies, health complaints, factors of instability, attitudes toward the Navy and their own evaluation of their adjustment in the Navy, and the presence or absence of personal problems.

The data for this study were obtained from a special questionnaire prepared for use in the psychologic screening of all men admitted to a Disciplinary Barracks of a U. S. Naval Receiving Station following their apprehension for some delinquent conduct while in the naval service. These delinquents include AOL (absence

over leave), AWOL (absence without leave), shirking duty, intoxication, theft, insolence, etc., as well as difficulties with civilian authority while on liberty or leave. These men represent practically a cross section of the United States with, however, a predominance of men from the southeastern areas because of the location of the station. The following table shows the geographic distribution of the 200 "only children" herein referred.

GEOGRAPHICAL DISTRIBUTION OF 200 "ONLY CHILDREN" NAVAL OFFENDERS

Alabama	4	Illinois	9	New Jersey	6	Texas	8
Arkansas	2	Kentucky	5	New York	26	Virginia	8
California	6	Louisiana	4	North Car.	10	Wisconsin	1
Colorado	1	Mass.	9	Ohio	8	Washington	2
Connecticut	3	Maryland	8	Oklahoma	1	West Va.	3
Delaware	3	Michigan	6	Penn.	22	District of Columbia	2
Florida	9	Minnesota	1	Rhode Island	1		
Georgia	7	Miss.	2	South Car.	10		
Indiana	4	Missouri	3	Tennessee	6		
TOTAL							200

THE DATA

Part (a)

The table that follows summarizes briefly the statistical results of the comparisons of 200 "only children" male naval offenders with the results of another study of 500 unselected male naval offenders.[1] The table is somewhat self explanatory to the statistical reader and hence no detailed comments are presented.

From the following table it is noted that the educational achievement of the unselected group is only slightly higher than that of the "only children" and that the chances are about 96 in 100 that the true difference between the two groups is greater than zero and in favor of the unselected group of naval offenders.

With reference to the length of service it was found that the "only children" as a group tend to have a greater number of months in service at the time of this study and the difference is found to be statistically reliable. The reasons for this fact are highly speculative. There may be the eagerness of some "only children" to break away from the strong over-solicitous home and to declare their independence in the Navy. Also, there may be a strong urge for a broader companionship that is found in the Navy for them. This presumption may also be strengthened by the fact that although the "only children" are older as a group before entering the service they

entered the service sooner. This is only a conjecture without too strong confirmation.

With respect to the number of offenses accrued in the Navy up to the time of this present investigation it appears that the unselected group of naval offenders have a greater number on the average which when tested for its statistical reliability indicated significance.

TABLE OF STATISTICAL RESULTS OF THE COMPARISONS OF THE GROUPS

	Education (Highest grade completed)		Length of Service (in months)		Age (in years)		Number of Offenses	
	"Only Children"	Unselected Group	"Only Children"	Unselected Group	"Only Children"	Unselected Group	"Only Children"	Unselected Group
Mode	11.0	8.50	6.00	12.00	19.0	19.0	1.0	1.50
Median	9.49	9.22	13.9	9.9	20.55	20.79	1.22	1.22
Range	3rd. to 15th.	3rd. to 15th.	2 to 61*	2 to 55	15–45	15–40	1 to 7	1 to 8
Mean	9.11	9.43	16.7	12.15	22.31	20.45	2.09	2.52
Difference		.32	4.55		1.86			.43
$\sigma_{\bar{M}}$ mean	.155	.098	.79	.343	.340	.154	.116	.058
$\sigma_{\bar{M}o\text{-}Mun}$ Diff.		1.83	.861		.374			.130
$C_{\bar{M}o\text{-}Mun}$		1.75	5.28		4.97			3.30
$\sigma_{\bar{O}}$	2.19	2.21	11.25	8.67	4.86	3.46	1.65	1.20
Difference		.02	2.58		1.20		.45	
$\sigma_{\bar{O}o\text{-}Oun}$	.109	.069	.56	.274	.243	.109	.082	.037
$C_{\bar{O}o\text{-}Oun}$ Diff.		.130	.623		.266		.090	
$C_{\bar{O}\bar{o}\text{-}Oun}$		.154	4.14		4.51		5.0	
N	200	500	199	500	200	500	200	500

* One case—146 months not included in the distribution for length of service.

The "only children" as a group show a greater degree of variability in the measures of length of service, age and the number of offenses and the differences so obtained are statistically significant. In the measure of degree of education, the unselected group showed only a very slight tendency toward greater variability but it is not significant.

In summary the data indicate that the "only children" as a group have been in the Navy longer and entered the service at an older age. Higher educational achievement as well as more offenses on the average were found with the unselected group of naval offenders.

Part (b)

The following section aims to present various types of data that were obtained from the questionnaire used in the psychologic screening of the naval offenders. The data are presented in percentages, comparing the findings of 200 "only children" male naval offenders with those of 1,000 unselected male naval offenders.[2] The question and answer method is utilized to facilitate the presentation.

NAVAL HISTORY

		"Only Children"	*Unselected*
(a) What are the proportions of these groups Regular and Reserve Navy?	Regular	15.50%	15.30%
	Reserve	84.50%	84.70%
(b) Enlisted or drafted?	Enlisted	64.50%	60.90%
	Drafted	35.50%	39.10%
(c) Average length of service in the Navy?	Range	2 to 61 mo.	2 to 55 mo.
	Average	16.7	12.15
	$O_{\bar{m}}$	.79	.343
	$O_{\bar{}}$	11.25	8.67
(d) Average ages?	Range	15 to 45 yrs.	15 to 40 yrs.
	Average	22.31	20.45
	$O_{\bar{m}}$	.340	.154
	$O_{\bar{}}$	4.86	3.46
(e) Rated and Non-Rated Men?	Rated	20.00%	13.00%
	Non-Rated	80.00%	87.00%
(f) First offender or Recidivist?	First	43.50%	45.00%
	Recidivist	56.50%	55.00%
(g) Average number of offenses?	Range	1 to 7	1 to 8
	Average	2.09	2.52
	$O_{\bar{m}}$	.116	.058
	$O_{\bar{}}$	1.65	1.20

FAMILY BACKGROUND

		"Only Children"	*Unselected*
(a) Father living?	Yes	65.50%	73.50%
	No	35.50%	26.50%
(b) Mother living?	Yes	77.50%	84.10%
	No	22.50%	15.90%
(c) Divorced or Separated?	Yes	24.50%	18.43%
	No	75.50%	81.57%
(d) Stepmother?	Yes	5.00%	7.50%
(e) Stepfather?	Yes	12.50%	11.10%
(f) Brothers and Sisters?	Yes	0.00%	91.98%
	No	100.00%	8.02%
(g) Half-brothers and Half-sisters?	Yes	0.00%	9.40%
	No	100.00%	90.60%
(h) Reared in foster-home or orphanage?	Yes	3.50%	4.60%
	No	96.50%	97.70%
(i) Does he think he had a happy home as a boy?	Yes	83.50%	86.30%
	No	16.50%	13.70%

MARITAL STATUS

		"Only Children"	*Unselected*
(a) Is he single?	Yes	69.00%	66.99%
(b) Is he married?	Yes	31.00%	33.01%
(c) Has he children?	Yes	53.22%	51.80%
	No	46.78%	48.20%
(d) Is he happily married?	Yes	91.93%	82.70%
	No	8.07%	17.30%

EDUCATIONAL BACKGROUND

		"Only Children"	*Unselected*
(a) How far did he go in school?	Range	3rd. to 15th.	3rd. to 15th.
	Average	9.11	9.43
	σ_m	.155	.098
	σ	2.19	2.21
(b) Did he think he learned well in school?	Yes	81.50%	72.30%
	No	18.50%	27.70%

DELINQUENCY BACKGROUND

		"Only Children"	*Unselected*
(a) Play "hookey"?	Yes	43.50%	47.70%
	No	56.50%	52.30%
(b) In juvenile courts?	Yes	5.50%	11.00%
	No	94.50%	89.00%
(c) Arrested in civilian life?	Yes	23.00%	27.10%
	No	77.00%	72.90%
(d) Was he ever in jail?	Yes	19.50%	22.10%
	No	80.50%	77.90%
(e) Reform School?	Yes	2.00%	3.10%
	No	98.00%	96.90%
(f) Prison?	Yes	2.00%	3.00%
	No	98.00%	97.00%

HEALTH COMPLAINTS

		"Only Children"	*Unselected*
(a) Does he report health complaints when he arrives at the "brig"?	Yes	41.40%	43.70%
	No	58.50%	56.30%

The complaints listed from the 1,000 naval offenders were tallied and have been reported in another article.[1] There were 469 different complaints registered from 437 men or about 1.07 per man. Similarly the complaints were tallied for the "only children" and there were 259 complaints from 117 men or about 2.21 per man. The nature of these complaints are often psychomatic in type and exaggerated by the fact that the man has been confined and is seeking sympathy of some kind.

ATTITUDES TOWARD THE NAVY

		"Only Children"	*Unselected*
(a) How well does he like the Navy?	Fine	44.50%	44.80%
	Fair	43.00%	42.60%
	Not at all	12.50%	12.50%
(b) How well does he like his duty?	Fine	35.50%	36.70%
	Fair	31.50%	35.80%
	Not at all	33.00%	27.50%
(c) How well does he think he is getting along in the Navy?	Fine	23.50%	25.30%
	Fair	48.50%	48.10%
	Not at all	28.00%	26.60%

FACTORS OF INSTABILITY

		"Only Children"	*Unselected*
(a) Does he complain of trouble in sleeping?	Yes	26.50%	34.50%
	No	73.50%	65.50%
(b) Does he consider himself to be a nervous person?	Yes	47.50%	47.30%
	No	52.50%	52.70%

PERSONAL PROBLEMS

		"Only Children"	*Unselected*
(a) Does he state that he has some personal problems he wishes to discuss?	Yes	43.00%	38.20%
	No	57.00%	61.80%

"NP" REFERRAL

	"Only Children"	*Unselected*
(a) What per cent of these two groups were referred to the psychiatrist for further study?	13.00%	11.10%

The personal problems center chiefly around mental hygiene problems regarding home difficulties, marital adjustments, financial worries, health complaints, homesickness and many other factors that result when one is away from home and home obligations. Many of these are somewhat alleviated through referral to other departments of the Navy that work with the naval offenders. A detailed elaboration of the importance of these factors in producing naval offenses is not attempted in this article but have been discussed at length in another article.[3]

SPECULATIVE CONCLUSIONS

The rather extensive interpretative conclusions that might be drawn from these data herewith presented are left to the reader. Some may be supported by the data while many others might be implied. The subtle factors in personality that might differentiate those two groups more strongly are not indicated by the data but are nonetheless important considerations. From the data the following conclusions are stated:

1. On the average the unselected group showed a slightly higher academic achievement by highest grade reported completed.
2. "Only children" as a group tended to be older than the unselected group but have had more months in the naval service.
3. "Only children" tended to have fewer naval offenses on the average than the unselected group.
4. The difference in percentages between the two groups of first offenders and the recidivists was negligible.
5. A greater per cent of "only children" have no father or no mother living. This may explain the fact that they are "only children".
6. More "only children" come from homes where the parents are divorced or separated. This, too, explains the "only" factor.
7. "Only children" tended to have more stepfathers and fewer stepmothers than the unselected group.
8. More "only children" were reared in a foster-home or orphanage.
9. A few more "only children" than the unselected indicated an unhappy home as a boy growing up.
10. The two groups are approximately the same relative to being single or married but the married "only children" showed a greater number of happy marriages.
11. A greater per cent of the "only children" than the unselected offenders as a group indicated that they learned well in school.
12. "Only children" indicated they played "hookey" less than the unselected.

13. "Only children" made fewer appearances in juvenile courts than did the unselected group.

14. The two groups showed less difference in the per cent comparison of civilian arrests but the comparison favored the "only children".

15. The data indicated that fewer "only children" had had reform school and prison experience prior to the Navy.

16. In the matter of health complaints there were no marked differences between the two groups as a whole but the "only children" reported over twice the number of separate complaints per person on the average than did the unselected men.

17. There were practically no differences noted between the two groups with respect to attitudes toward the Navy, the duty or the adjustment in the Navy.

18. "Only children" had fewer complaints about trouble in sleeping.

19. "Only children" had more personal problems which they wished to discuss.

20. "Only children" were referred to the psychiatric office for neuropsychiatric and mental hygiene problems more often than were the unselected offenders. The difference, however, was not great.

In conclusion the findings of this study add support to the findings reported by the earlier investigators but do not clearly indicate the inferiority or the superiority of the "only children". Previous studies have been with children chiefly. This study deals with more mature and older individuals who have been living under the influence of the "only child" atmosphere longer and probably are more important to study for any effects. There may be periods in the developmental background where this influence is stronger than in others, thus the adult "only child" may furnish a more fertile field for future psychologic research.

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RORSCHACH CONTENT ANALYSIS

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The purpose of this paper is to demonstrate a short simplified technic that can be useful in the interpretation of a Rorschach record. The method that will be used here is qualitative and based almost exclusively upon content; yet it has proved invaluable in facilitating an understanding of the more significant dynamic trends of the subject (particularly in regard to self-assertive tendencies). The procedure that will presently be discussed is to be used only as a clinical tool. It is not novel—but rather an integration of various bits of known information regarding the Rorschach test.[1]

In responding to the visual abstractions presented on the plates —the subject is, of course, projecting his own feelings and thoughts —both conscious and unconscious; hence the content should furnish a great deal of useful information concerning the individual's repressions and coping mechanisms. It should therefore be possible to utilize a qualitative technic of evaluating a Rorschach pattern, from a clinical standpoint, in a small fraction of the time taken with the present scoring methods. Such a procedure may furthermore yield additional information which otherwise would not be available.

If S sees either animals or humans in a weak, defenseless, submissive role—it would mean that he, in reality, possesses these feelings—either consciously or unconsciously.

However, it might be said that the individual is projecting his attitudes about the environment—the need to feel that others are weak and can easily be manipulated. Let us assume for the purpose of argument that such are his genuine attitudes. Under these circumstances, however, they would only be a secondary consideration to the subject—a result of his more significant feelings about himself. Of paramount importance to him would be *his* role in society, stemming from his need to be assertive, domineering or aggressive. His pattern should therefore present, primarily, his own desire for power as he experiences it in terms of himself—rather than the results of such needs—namely, the suppression of others or desire to place others in a weak position. Hence the perception of "weakness" or "inadequacy" must always be a personal projection of impaired potency or need to be compliant. Similarly the perception of strength,

[1] The method is most feasible when the subject is known to be maladjusted.

aggression or hostile activity would indicate a need to compensate —or be assertive. (Hostile impulses or aggressive needs—as well as inferiority feelings may be repressed, depending upon other factors which are either present in, or implied from, the pattern).

If hostile activity is depicted it might again be argued that it is a projection of one's feelings about people (belief that people are hostile to the subject). However, if this is so—such feelings would inevitably be associated with basic anxiety or insecurity resulting in hostility toward people either on conscious or unconscious level. Anxiety and hostility are inextricably interwoven.

In all probability the perception of a dualistic hostility situation, e.g.—people or animals seen fighting, quarreling, etc., would signify aggressive conflict with people—together with insecurity feelings.

The subject will often perceive contrary types of behavior in the pattern, e.g.—submissive qualities and assertive elements; however, in such cases the latter will almost always be a result of the former and both—highly personal feelings.

In utilizing our technic we cannot determine "degree" to any appreciable extent. As has been stated above, this method of analysis, which will be outlined at the end of the paper, is qualitative. Besides, the purpose of our paper is not to offer a diagnostic technic, but a means of understanding the subject's self evaluation, security feelings, motivations, coping mechanisms or role in life, etc. Hence it would not be necessary to "split hairs" or determine exact relationships.

Much can be learned about the subject from the words and gestures he uses in responding. They may be indicative of the external role and integrated with the pattern, although they probably are to a large extent, an outgrowth of intellect and training.

The observer can learn a great deal about the subject's external role—from his persistence in responding, need for perfection in detail, tendency to be overcautious, etc. Such tendencies probably indicate compulsive—obsessive trends, abulia, etc.

If the subject does not give many responses—or takes much time in "deciphering" the plates, he is probably strongly repressed.

Some people may make a feeble, unsuccessful attempt to decipher the blot and then return the plate to the examiner without applying themselves further. Such behavior would indicate a need to avoid mature adult problems by change of activity, in a crisis or situation pervaded with problems, to something less difficult or threatening—an attempt to escape adult responsibility—an indifference to the external situation when it becomes "tough".

Childishness or immaturity, regressive tendencies, etc., can be

largely determined from the subject's descriptions and his choice of language (may also be indicative of low intelligence). Infantile activities seen in the pattern also point to these trends.

In returning to our previous discussion the idea cannot be overemphasized, that any indication of weakness or inadequacy, flexor movement, etc., perceived in the pattern would be a definite projection of highly subjective impaired self esteem or feelings of inferiority.

Similarly assertive or aggressive percepts would point to a desire to be in "control of the situation" or to strike back against a threatening world.

If the elements of "weakness" seen in the pattern are obvious —a direct expression of inadequacy as babies or figures hanging, bending, or "lying down" for example—there probably is little suppression of inferiority feelings, unless "dignified" and aggressive elements are also present.

If S sees weak, queer, or derogatory figures or symbols as well as symbols of dignity (e.g.—beard, crown, badge) or aggression—we would know that feelings of worthlessness or helplessness are present together with a need to compensate outwardly.

When a subject sees dignified figures (e.g.—"person well dressed", "professor") or symbols, but does not present any direct features of impaired self esteem (this is rare)—they, (the latter) may nevertheless be present in an unconscious state by implication of the need to assume the particular facade, if elements of insecurity (to be discussed) are also present.

In order to exert a determining influence the "dignified" or assertive elements should be clear—obvious (human extensor movement is also highly indicative of self assertion) as well as "personal" or related to animate forms. (An article of clothing such as "tuxedo" would be classified under Dignity Symbol.)

When the figures are seen in an aggressive role but suspended—hanging or in a position which would appear to render them impotent—the observer can justly assume that although the subject does possess hostile or aggressive trends, his feelings of personal weakness render him incapable of giving vent to these emotions outwardly. Hence he would repress such tendencies.

Sometimes a subject will see an article of clothing hanging. This is probably a direct "depersonalization"—a distortion of the subject's own feelings of helplessness.

The absence of "human beings" is indicative of insecurity—basic fear or distrust of people together with hostility (particularly when

entities such as witches or devils are seen), as well as impaired self esteem which is, to a large extent repressed (with resultant "overbearing" attitudes)—if one or more aggressive or assertive symbols are also seen.

If an individual's perceptions of inadequacy [1] and assertive elements are more or less quantitatively equal—they would usually indicate substantial repression of the "feelings of weakness."

If the indications of inadequacy greatly outweigh the assertive elements (assuming the latter to be quantitatively equal to not more than one or two)—then the individual would still be conscious of what he feels to be his weakness although he would be "fighting back" too developing counter mechanisms.

If no human movement [2] is seen, feelings of inadequacy and lack of genuine initiative are pronounced, and if no assertive or aggressive trends are indicated, then this feeling of inferiority may be partly conscious. If contrary trends are also indicated (even only once or twice) then the "weakness" may be completely repressed and the individual "overbearing" in his attitude.

We may often have dubious responses which should be carefully examined to avoid serious errors in interpretation.

e.g.—A knight in armor on a horse—may be associated with dignity or assertive needs, or with a desire to be kind—courteous—gentlemanly. The armor may be symbolic of defensive tendencies on the part of the subject.

If a subject sees an incomplete "dignity" symbol such as "part of a crown," it may indicate some need for assertion—with adverse feelings, or misgivings, resulting in suppression or denial of these impulses.

In cases of doubt it is desirable to use "free-association" with particular responses—either in the inquiry or after the test has been completed.

If S sees animals or human beings in a benevolent or cooperative role (favorably disposed toward each other) there would be a significant indication of a need to be "liked", to repress hostility, to cooperate with people. Responses such as churches, angels, social symbols, etc., point to similar needs on the part of the testee.

Evidences of "benevolent" percepts would leads us to suspect the presence of guilt feelings (perhaps due to hostile inclinations) in addition to fears of eliciting hostile reactions from one's environ-

[1] Dwarfs, children or small people (perhaps even small creatures) can be classified under "perceptions of inadequacy."

[2] "Human movement" refers to any "human-like" activity including movement of monkeys, witches, etc.

ment (definite insecurity feelings may be implied—particularly if the pattern directly indicates elements of anxiety, hostility, or other adverse trends).

Color responses are also indicative of social needs and point to "extrovert" tendencies (including tendencies to be emotional).

A subject may inhibit his color responses. (He may give more responses to the colored plates, yet not be affected by the color outwardly in his descriptions). This would point to a repression of needs for warmth—companionship, emotional involvement, resulting in a conscious desire to be free of people—self sufficient.

Fears of emotional involvement are implied by figures acting in opposite poles—looking in opposite directions—or any role which may be symbolic of such an approach.

If hostile behavior and benevolence are seen, and if the subject has a tendency to give bizarre responses—confabulations—then the two aspects may alternate strongly in life. (Inconsistent behavior is common with psychotics). Neurotics usually tend to develop a consistent outer trend or coping mechanism which is fairly stable.

We have implied that if the individual sees hostile or aggressive activity as well as weak or impotent entities, he may or may not express his aggressive impulses—depending upon other factors such as the specific role of the hostile beings or an indication concerning the kind of aggressive needs—passive or active (already partly discussed above).

Thus, when the individual perceives aggressive activity but does not "feel" that there is any specific tendency toward direct action depicted, it would indicate passivity (inhibitive forces)—repressed feelings of aggression—feelings of inadequacy in a hostile threatening world with consequent fear of evoking hostile reactions from the environment. If such a person also perceives benevolent activity at the same time we would have a certain indication of a fear of hostile expression with feelings of guilt, as has already been discussed.

Active aggressive impulses—such as freedom to act in an aggressive manner—indication of extensor movement—tearing—pulling—snarling—arguing—fighting—etc., without implication of restraint, would probably indicate overt aggressive tendencies; however, even in such cases there may be evidence of some repression of these impulses—depending upon other factors such as cooperative activity, benevolent behavior or symbols, and other trends already discussed.

Similarly if no aggression or hostility is seen in the blots, it may be strongly repressed and still exist unconsciously, by implication of the total content pattern. If there are pronounced indica-

tions of anxiety (to be discussed) together with feelings of impaired worth, hostility must be present in some form. Hence if it is not seen in the plates, it must be completely repressed.

Figures seen climbing or ascending is a healthy trend; falling figures indicate pronounced pathology—particularly when the test pattern is one of impaired self esteem.

Although the quantity of various types of compliant or assertive responses may not be marked—they still are usually highly indicative. Even if only one card shows one or more of the above trends, the interpretation can still be similar; in such a case there may be greater inhibition along certain lines.

When a subject does not see human figures particularly on plates where such responses are exceedingly common (2 & 3)—we can safely conclude that pronounced feelings of insecurity and inadequacy exist.

If shading is a determinant of the perception, anxiety is present—a fear of the environment resulting in a need to be cautious. If a subject sees "blackness" or "darkness" we are confronted with a "danger" signal; such a subject tends to feel hopeless—"lost".

"Masks" are symbolic of pronounced anxiety—a fear of one's feelings or thoughts resulting in a need to "cover-up"—repress them. "Blood" is also highly indicative of anxiety.

A bearded figure or old man seen on a plate may conceivably represent the father—an old woman, the mother.

If a subject sees the sex organs of his or her own sex to an appreciable extent (more than once or twice) it would probably indicate feeling or fear of sexual inadequacy, with need to reassure oneself of sexual potency; another possibility is homosexuality. When S sees sexual organs of the opposite sex we may reasonably assume that he is preoccupied with sex.

Symbolism in general would have the same connotation as in dreams.

OUTLINE

1. Feelings of Inadequacy and Inferiority: Any perception of figures, personal symbols, or activity—indicative of impotency, inadequacy or weakness, foolishness, dependence or compliance (flexor movements and absence of human movement—highly indicative of such trends).
2. Assertive Tendencies: Perceptions of achievement, extensor movement, figures or symbols of dignity or power.
3. Aggressive—Hostile Tendencies: There is much overlapping with "2". Highly indicative of such trends are any antago-

nistic figures, activities or symbols. (Absence of human beings—indicative of "anxiety-hostility").

4. Kindness—Generosity—Cooperative tendencies (In External Role): Benevolent symbols (churches, angels, etc.); social activity implying unity of purpose, cooperation, etc. (feelings of guilt may be implied).

5. General Insecurity Feelings—Anxieties—Pathologic trends: Perception of texture, masks, darkness, hostile activity, figures acting in "opposite directions", no color responses, no (or very few) human beings, figures falling. Can be implied from other tendencies—e.g., feeling of "weakness" and repression of assertive or aggressive trends, etc.

6. Tendencies toward Health: Improvement over previous state. Symbols of optimism—e.g., "lighthouse" (subject's associations with the symbol would determine its significance); figures seen climbing or ascending.

Through the proper integration of these factors, in the manner previously described, I have endeavored to demonstrate that an analyst can gain an invaluable understanding of intricate dynamic patterns and reactive mechanisms—by applying his knowledge of psychoanalytic theory and clinical pattern analysis.

In utilizing the content approach to Rorschach analysis the reader must be aware that even a "normal" subject, to a certain extent, may possess the tendencies discussed above. If the subject is known to be maladjusted, however, these trends or strivings would assume greater significance and would enhance our understanding of his personality. (The trends were actually discussed in terms of maladjustment).

In some cases the subject's percepts will be influenced by his recent experiences—and therefore not quite as indicative as the test pattern would imply. Hence, for best results, the subject should be questioned to enable the examiner to determine whether there actually has been a change in the subject's situational conditions.

"Free association" should be used whenever feasible.

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Abstracts from Current Literature

Clinical Psychology

A RORSCHACH STUDY OF PSYCHOPATHIC DELINQUENCY.

D. E. Bowlus and Anna M. Shotwell. Am. J. Ment. Def. 52:23-30, July 1947.

The difficulty in defining the term "psychopathic" is discussed by the authors. From a practical viewpoint the type of juvenile delinquent who does not measure up as insane but shows an intractable abnormal behavior meets the requirements of the definition. Structural weaknesses in the personality are readily demonstrable but they are almost untreatable.

The author's studies include consideration of 12 girls who have lead lives of ridiculously planned, rebellious behavior. Their intelligence quotients placed them in the dull normal class. Although the series is quite small, the authors consider the cases so typical as to enable them to draw conclusions based upon Rorschach study. A surprising agreement in the records occurred in bringing out qualities of superficialty, avoidness, exclusiveness, incompleteness, and egocentricity in the series of girls. The pattern of responses to the Rorschach test are so well-delineated that it can almost be termed indicative of the psychopathic delinquent girl. She is slow and unproductive, intensely lazy and impracticable. Her thinking is always badly organized. She focuses upon banal, stereotyped and uncreative activities. Her capacity for emotional response is shallow and meager. She acts impulsively but always in an immature manner which leaves her vulnerable to any unusual circumstances. Frivolity is quite characteristic and when it is combated in any manner, the girl retreats into an attitude of brash defiance. In her better moments she is coy and flirtatious. Her mind does not center upon any given objective but is inclined to be flighty so that sketchiness and carelessness are characteristic of her thinking. She interprets everything about her in terms of what it means to her personally. She is not interested or sympathetic with the aims of people other than herself. The author characterizes the pattern under the five terms of "frivolousness, coyness, flightiness, sketchiness and self-centeredness."

From the viewpoint of specific responses to the Rorschach test, response time was found to be slow, and quick rejection of cards occurred in 30 per cent of the cases. This suggests a passive will-to-fail, thereby robbing the conscience of any grounds for complaint. The group average was 41 per cent for Whole responses. Detailed

responses were few and indicated a general tendency towards preoccupation with nonessentials. Lack of self criticism was indicated by excess of four W over M. The F responses gave a picture of drabness, a sort of threadbare personality. The immaturity of the individual was indicated in part by an excess of F M over M responses. Color and shading disturbance were scattered in general. The interpretation of the findings as a whole indicated vulnerability in an essentially immature person. The only course of treatment in such an individual is to treat him as a child and to arrange for his training and management on that level.

Neuropsychiatry

SLEEP WALKING AND SLEEP ACTIVITIES.

M. Narasimha Pai. J. Ment. Sc. 92:756-65, October 1947.

The majority of cases of sleep walking have a psychogenic causation, usually an anxiety state. The condition is clearly illustrated by "battle dreams" in which the soldier relives his military experiences in his sleep . There is great psychomotor activity and the patient may become so violent as to knock down furniture, fall through windows and walk or run furiously. The intensive sweating and state of terror with rigid muscles, rapid respiration and dilated pupils, are clear indications of the marked state of anxiety underlying the condition. During the day such patients may show a milder state of acute anxiety, such as sweating, tremor, frequent urination and apprehension. These acute cases finally yield to sedation and psychotherapy.

The chronic cases are much less intensive in their reactions and by the same token are more difficult to cure. The patient usually has a long history of neurotic traits in childhood, such as enuresis, nail biting, stuttering and sleep walking. The therapeutic approach is that of an attack upon the personality problems of the patient rather than through the use of prolonged sedation.

The third sub-type of those cases having purely psychogenic causation is the individual showing hysterical association (somnambulism). Dissociation occurs during sleep and is accompanied almost invariably by walking movements. The patient has no knowledge of his actions upon awakening. It would seem as though two distinct streams of thought existed without any mergence. While the person is sleeping, the basic personality is in abeyance and repressed desires avoid the inhibitions placed upon them by the personality during the waking state. In sleep walking the individual carefully

avoids injuring himself or others. He seems to be able to go about as if he were thoroughly familiar with total darkness. He is at perfect ease and appears as if he were awake, his eyes being open and his ability to respond to sensory impressions being unimpaired. Usually he does not reply to questions. During the daytime in contrast to the two preceding types of cases, he shows no anxiety. The type of therapeutic approach is hypnosis.

Among conditions which are nonpsychogenic, sleep walking is an occasional accompaniment of epileptic states. Somnambulism may occur following a seizure. The condition of petit mal epilepsy is a momentary trancelike state without the opportunity for violent action and is closely allied to somnambulism. Occasionally the conditions of automatism of this kind have been introduced into medicolegal cases by the defense where the question of criminal responsibility has arisen. The condition is so rare, however, that it has not received any established recognition in the courts, as a defense for responsibility. The diagnosis of doubtful cases is affirmed by the EEG. Hypnosis is not of any value in these cases. The treatment is directed essentially towards modifying the course of the epilepsy itself.

Encephalitis nearly always is accompanied by disturbances of the sleep rhythm and it may be a most annoying residual symptom. There is abundant evidence that cortical interference is the causation of the sleep disturbances, since the regulation of the sleep mechanism appears to be localized in the region of the angular, frontal, premotor and temporal convolutions. Patients of this kind may wander about the street at night in state of somnambulism. Sedatives are of value in relieving these cases.

Malingering of sleep walking may occur. The patient of course is fully aware of what he has done. If a flashlight is thrown into his face, he may close his eyes tightly and resist attempts to open them. Startle reaction may be shown. All of these reactions are absent in the true case of sleep walking.

THE SYNDROME OF INHIBITION.

Sidney Tarachow. Psychiat. Rev. 21:233-52, April 1947.

Through prolonged observation of neurotic patients the author has been able to formulate a combination of symptoms which he has entitled "The Syndrome of Inhibition." These are enumerated by him as follows: "(1) Fatigue. (2) Migraine and other Vasodilatory Phenomena. (3) Depressed Immunity to Infection. (4) Depressed Menstruation. (5) Psychogenic Pain. (6) Potentiation of

the Cough Reflex. (7) Increased Sleep. (8) Gastro-Intestinal Inhibitions. (9) Glandular and Mucous Membrane Inhibitions. (10) Itching-Red and Urticarial Skin Lesions and Paradoxical Reaction to Cold."

Each of the above symptoms has received some discussion and delineation by the author. Each is illustrated by case material. Fatigue is the result of flight from aggressiveness leading to a position of passivity. Migraine and other vasodilatory phenomena were observed to be either as a part of the inhibition of a state of tension, or to have occurred at the abrupt collapse of a high state of tension into relaxation. Coughing is frequently brought about by inhibition. The cough reflex is frequently observable in public speakers who are under highly repressed emotion. The reflex is also exhibited in patients who are telling an untruth or who are visibly embarrassed in any particular situation. The gastro-intestinal inhibition is the most easily observed. Abdominal distention is most likely to occur at periods of indecision. The constipation accompanying such states is usually intractable.

To the above set of symptoms the author adds a secondary chain which probably are inhibitory in nature. These are angioneurotic edema, vertigo, dryness of the scalp and pruritus ani. All of these symptoms show diminished function. The organism is evidently in a state of inhibition about a situation. Anxiety is showed clearly and the bodily defenses are not readily mobilized. The type of patient in whom the syndrome of inhibition is most frequently observed are the reactive depressions and the obsessives. The anxiety and phobic states are infrequently encountered in this syndrome. The author draws the conclusion that the tensional states accompanying the syndrome are not true anxiety conditions. They are not even anxiety equivalents. They are what he terms "Inhibition equivalents" and represent the inability of the individual to mobilize his defense resources. If the interfering conditions, however, are not overwhelming compensatory reactions will occur and then occurs the syndrome of over mobilization.

Psychotherapy

PSYCHOTHERAPY OF THE OBESE PATIENT.

Henry B. Richardson. New York State J. Med. 47:2574-78, Dec. 1, 1947.

The discussion of obesity in this paper is limited to the exogenous type. The problem involved is that of caloric intake and balance. From a psychologic point of view appetite is a craving and must

be combated. As a matter of fact, obesity is really a disease for it causes suffering and jeopardizes the life of the patient. The technic of treatment employed by the author corresponds closely "to the associative and anamnesis" of Felix Deutsch. In this manner he ascertains the spontaneous association between the physical defects of the patient's illness and its mental and emotional components. By such method the relationship between mind and body become apparent. Leading questions are avoided. Material obtained from the patient during an emotional state is most revealing. The interview becomes a conversation with a relatively small amount of questions and answers. Stops in the conversation are disquieted but it is well to allow the patient to resume the conversation. In this way the highest degree of association is obtained. The patient is allowed to unburden herself, to see her problem in perspective, to verbalize her frustrations and to express resentment. Overeating which leads to obesity is usually accompanied by anxiety, feelings of guilt and depression. Anxiety frequently gives a very good imitation of hunger-feeling for it is an emptiness inside.

The most important part of the psychotherapy is to uncover the association connected with her emotional life and thereby discover the excess drive for eating. The patient will resist this of course because it threatens her sense of security. If possible the patient must find out the motivations of her overeating through the therapeutic interviews. The therapist should not undertake an explanation and thereby provide the basis of an upset until the patient is ready to have a suitable substitute. Deeper investigations of motivation should not be attempted unless the physician has had competent training in the field of psychiatry.

PSYCHOTHERAPY FOR THE GENERAL PRACTITIONER. A PROGRAM FOR TRAINING

Thomas A. C. Rennie. Am. J. Psychiat. 103:653-60, March 1947.

The discussion is limited to the education of the general physician in simple principles of psychotherapy. The material is drawn from a course given at the University of Minnesota during April 1947 and financed by the Commonwealth Fund as a special experimentation. The group consisted of 25 doctors in general practice under varying conditions as well as from different sizes of communities. All were 50 years or less in age. The group represented a fair cross section of the average general practitioner of medicine.

An extraordinary rapport developed between instructors and

students. There was little doubt about the eagerness of the individuals in the group to learn as much as they possibly could. Following class sessions, groups would split off into ardent "bull sessions." The free give and take of the group led to a high degree of development of the seminar and Socratic method of teaching. This procedure prepared the student for his first psychiatric contact with the patient. Methods of interviewing and a development of adequate history taking were stressed in the early days of the course. As far as possible the material was related to the type of patient usually encountered by the general practitioner. The relationship of emotion as involved in physical illness was particularly stressed.

The next phase in the teaching process covered the development of the normal personality through the various channels of psychosexual life, social development through the family, school, occupation and religion, the importance of interpersonal relationships, physical and emotional development. Interference with any of these lines of development, either by deviation, arrest or regression, were made the basis of the beginning study of psychopathology. Reaction patterns were outlined and the broad diagnostic psychiatric categories based upon them were traced. From this background the group was ready to undertake a more detailed analysis of the neurosis.

Neurotic patterns, defenses and evasions and the common defense mechanisms were major considerations at this point in the course. Anxiety as a type of reaction between personality and environment, provided an easy transition into the study of psychomatics which perhaps was the most important section in psychiatry that the general practitioner could undertake. Treatment was related specifically to the kind of conditions encountered by the general practitioner; namely, headaches, peptic ulcers, cardiac disturbances, asthma, arthritis and accidents. The seminar approach was found to be most useful in discussing patient-physician relationship, the technic of the interview and the general principles of psychotherapy.

HYPNOTHERAPY.

Edith Klemperer. J. Nerv. & Ment. Dis. 106:176-85, August 1947.

The technic of hypnosis is a revival of procedures employed by Charcot, Janet and others in a somewhat new setting. More modern developments have permitted much of the incorrect observation and mystic beliefs of former years to be eliminated. An intermediate stage is encountered in the theory of Schilder and Kauders who developed the concept that hypnosis was an extrapyramidal

release phenomenon. The present discussion concerns itself primarily with the theory of hypnosis advanced by Kubie. Four different factors are differentiated by him for the induction phase of the hypnosis. First the patient under hypnosis regresses to the sensorimotor state of the first weeks of life. The ego boundaries become dissolved, ego past and ego present are blurred and the maximum attention of the patient has been secured. Second, the visual impact becomes inhibited. Third, maximum relaxation and expectation have been rhythmically secured. Fourth, freedom from all disturbing affects allows maximum concentration of attention.

The actual state of hypnosis itself, has a number of distinguishing characteristics according to Kubie. The patient regains in part at least, his ego boundaries in time and place and is again free to communicate with the outside world. This is likewise true of his sensorimotor limits. The hypnotist in part displaces earlier parental images and in part merges with them. The patient perceives his present environment as fused and integrated into older constellations. Thus there is no sense of superimposition of another will. The past as well as the present become indissolubly mixed for the patient at the moment. Interpretation and lines of action are drawn by the patient with this confused background. The author of this article does not feel that Kubie's concept entirely explains what occurs under hypnosis. She calls attention to the shifting values of hypnotic states in the same patient from time to time. A great deal more must be known about the process before an adequate explanation can be given.

The author's technic dispels some of the old ideas about hypnosis. A separate room with complete quietude is not necessary and in fact she has been able to induce hypnosis on disturbed wards. The belief one can resist hynosis if he has a stronger will than that of the hypnotist, is also untenable. If the patient cooperates the hypnosis is, of course, much more easily induced. The use of heavy and elaborate apparatus is unnecessary. The soft stroking of the forehead, as originally employed by Mesmer, has given adequate results in most instances. The feeling of close contact between the patient and the physician, is quite important. This is accompanied, of course, by suggestion. The hypnotic state is terminated slowly thus avoiding the sense of shock upon awakening.

The Menninger Clinic at Topeka, Kan., is doing an intensive study of the subject. Six different kinds of hypnoses are differentiated by this group, of which the last named is the one mostly employed, at the Menninger Clinic.

1. *Prolonged hypnosis:* The state of hypnosis is induced as deeply

as possible and for a prolonged period. This is a Viennese method and has not been used very much in the United States.

2. *Direct suggestion of symptom disappearance:* The most widely used method of hypnotherapy.

3. *Direct suggestion of disappearance of attitudes underlying symptoms*—The method is most applicable for the treatment of conversion hysteria.

4. *Abreaction of traumatic experiences:* Under sympathetic reassurance, the individual relives past painful experiences. This does not seem to be enough, however, since the results cannot be explained to the patient and he does not derive an understanding of the true basis of his conflicts.

5. *Specialized hypnotic technics:* Automatic writing is the best known of these.

6. *Hypnoanalysis*—By this method the technics of hypnosis and those of psychoanalysis are merged.

The author suggests that hypnosis as a therapeutic agent is most successful in the neuroses, insomnia and inreactive depressions. In certain cases of psychotics, the method may be of value.

Psychoanalysis

DISPLACEMENT GUILT AND PAIN.

Henry Hart. Psychoanalyt. Rev. 34:259-73, July 1947.

The libido has a certain fluidity of state which permits it to be channelized. Like most fluids, when their stream of flow is blocked, new channels will be sought. The displacement of instinctual energy occurs in every human being. When the displacement is abnormal, however, and when it fails to relieve the tension of frustration, emotional tensions arise. The direction of pathologic displacement may take varying pathways such as introjection from an external to an internal object; by projection from an internal to an external object; regression to earlier pleasures often at an infantile level; transfer from one part of the body to another; transfer of an affect to an idea. One of the most important of these displacements is that associated with repression where there is a sense of guilt and the emotional state of anxiety. The displacement is from the central part of the Ego to the periphery and takes the form of body symptoms (frequently pain). The organ selected as the site of the localization of the pain, symbolizes the guilty agent and thus becomes the body part of the object to be punished. Thus the displaced activity symbolizes the urge that is repressed and to this extent resembles the mechanism of sublimation which through displacement achieves a

partial satisfaction of the sexual drive. A certain sense of security and satisfaction results therefrom. The author believes that a certain amount of segmental distribution of displaced libido referred to the periphery can be found in parallel with a segmentation of the body itself. The analogy at best is only approximate. It is a well-known neurologic fact that sensory stimuli are received and interpreted by the cerebral cortex and are projected therefrom. The author suggests that possibly a similar integration and distribution of displaced guilt affect is cortically controlled.

Several forms of displacement are outlined by the author. In the first class he groups displacements of hate, aggression and destructiveness. The mechanism of projection is freely used. Others are made responsible for the hatred and fear engendered within the patient himself. A more complicated type of displacement is that encountered in the compulsion neurotic. By this mechanism the patient displaces from the really important issues to those that are relatively insignificant. Thus through rituals and repetitious behavior of a trivial sort, the affect is deviated into insignificant activity with partial relief from its painful tension.

The third type of displacement is zonal in nature and has already been commented upon. It is the principal form with which this paper is concerned. A number of instances are enumerated by the author.

HOMOSEXUALITY.

Isidore I. Weiss (Major, M.C., A.U.S.). Psychiat. Quart. 20:485-523, July 1946.

The material of this article refers to military prisoners throughout. The situation of throwing large numbers of men with insufficient channels of normal sexual expression conduces to a large number of unfortunate relationships in such a milieu. Latent homosexuality may often be brought to the surface. The author is inclined to deprecate the constitutional factor of homosexuality and to stress the condition as a total personality functioning in its environment. Most investigators have a feeling of hopelessness regarding the curability search and experimentation of a biochemical nature gives some promise. He offers the following definition, "Homosexuality has an inherent biochemical and psychobiological matrix which develops into a recognizable departure from the normal in adult life, with characteristic psychic, physical, and sexual components." It would appear that the excretion of estrogens increases more rapidly than androgens in homosexuals. Consequently biochemical changes in a complicated interplay of hormones have probably existed from birth in these individuals.

The freudian concept of homosexuality frankly concedes the biologic aspect of the deviation, and seeks only to explain the dynamisms involved. The object-choice of the homosexual results from an incomplete resolution of the Oedipus situation. "Of the three types identified, one flees, out of incest horror from the woman to man; a second identifies himself with the mother and seeks himself; he loves the boy as he himself would have liked to be loved by his mother." The third type arises from the curbing of aggression against the brother or father.

Bergler's theory that homosexuality may be the result of the wrecking of the breast complex, receives adequate discussion by the author. Identification of the penis and breast are made in male homosexuality.

The author estimated that homosexuality is found in about 15 per cent of the military prisoners. About 6 per cent of these are true homosexuals whereas 9 per cent are merely aggressive psychopaths who are contemptuous of social and ethical standards. They are really heterosexual in makeup but resort to homosexual practices in their limited environment. The practice of treatment of the first homosexual offense in a somewhat casual manner by the prison authorities, is to be deplored for it is precisely at this state that the most can be done therapeutically for the homosexual. Frequently these men are not homosexuals but are yielding under pressure of threat or for the purpose of some kind of gain at the instance of the true homosexual himself. Several cases are briefly cited to indicate latent homosexuality accompanied by anxiety and the possibility of a psychotic breakdown. Some of the characteristic reactions of latent homosexuals are embarrassment in undressing, urinating and taking showers before other men. Occasionally they act coquettish and perform little acts that seem to be feminine in nature.

Panic reactions are discussed with illustrative case material by the author. Episodes of excitement, confusion and depression are noteworthy. Following explosive behavior, they may become sullen and discontented. Latent homosexuals upon discovery of their condition may go to extreme efforts to convince themselves and others of their masculinity and potency. Flight into alcoholism is extremely common and is accompanied by excessive sexual promiscuity. This is not merely of the nature of excessive indulgence but it has all of the earmarks of a furious and impulsive determination for the victims to prove themselves. The instance of venereal disease is high, and adaption to camp life is difficult. Endocrine treatment with supportive psychoanalysis may be of some assistance.

THE DEPERSONALIZATION SYNDROME.

G. Tayleur Stockings. J. Ment. Sc. 93:62-67, January 1947.

The feeling of unreality may be a prominent symptom in anxiety states, obsessions and in some forms of schizophrenia and endogenous depression. The individual who is sensitive and imaginative is more susceptible, to depersonalization than is the extroverted personality. The condition is characterized by five cardinal symptoms—namely, reality-disturbance, affective disorder, thought-disturbance, cephalic paresthesia, and absence of projection features. There is also a high degree of responsiveness to anoxic therapy. The patient has the feeling that his body has been changed in some peculiar way. Various parts of his body may feel light or numb as if it were made out of rubber or wood. He feels as if his personality had been changed and that he were in fact two different people. A frequent sensation is that his body is detached and floating in air. He feels he carries on a conversation with people as a mere automaton. All this process, of course, is the beginning of dissociation of personality.

Derealization is a feeling that the world has become mysteriously changed so that objects look unreal, faraway or even distorted in shape. The patient feels as if there is some sort of a veil interposed between himself and the outer world. Usually the syndrome is composed of a combination of both derealization and depersonalization phenomena.

The emotional disturbances attending this syndrome are quite characteristic. A depressed apathy is accompanied by a feeling of bewilderment and a sense of strangeness in the environment. It is not the restless dullness of confusional states nor the profound depression of reactive states. There is not the anxiety and fearfulness encountered in the agitated depressive. The patient feels an inability to experience emotion and does not have any enjoyment of food or any other pleasures. There is an unpleasant feeling of emptiness in the head as if the brain were dead or had stopped working. Difficulty in thinking is marked and all sensory impressions lack normal vividness. There is no clouding of consciousness and memory; insight and judgment are not impaired. There are no hallucinations nor delusions which would indicate that the condition was psychotic. Psychomotor retardation is absent. On the other hand, there is a fear of insanity and considerable suffering and incapacity because of derealization. Distressing mental and body symptoms contribute markedly to inability to carry on the demands of everyday life. As a

rule, there are no suicidal tendencies. The patient feels bewildered and depressed but does not react violently to the situation.

The syndrome if untreated may last several months to a year or more. Apparently the patient is undergoing a form of withdrawal from reality and an escape from an intolerable situation. While recovery without residuals usually occurs, this syndrome may be the accompaniment of a true dissociation process.

Obviously, the slowing of cerebration, and unpleasant mental and bodily sensations indicate that the condition belongs to the dysoxic group of metabolic brain disorders. The thalamic centers and their cortical connections are chiefly involved, especially systems which have the function of interpreting somatic sensations and the relating of the self to the external world. Higher association centers involving hearing, sight and the frontal lobe motor systems are spared. The disturbed physiology of this nature is encountered in states of severe physical exhaustion due to overwork or physical stress or "battle fatigue." The condition may also be the result of a postinfective exhaustion state. Certain drugs are known to produce a derealization syndrome, particularly cannabis drugs, and the mescaline compounds. The latter drug has a specific depressant effect on the oxidation mechanism of the brain cells but the conclusion cannot be drawn that the depersonalization syndrome is necessarily a disorder of the cellular oxidation process.

The condition under discussion may be mistaken for the dysoxic form of schizophrenia. The true derealization state however has no projection symptoms, no disorder of language and thinking and there is good rapport and insight. The affective reaction of derealization is always appropriate. Obsessional thoughts, hallucinations and delusion-formation are absent. Of the organic conditions the only one that could be mistaken for a severe derealization state is the parkinsonian syndrome. Careful neurologic examination readily settles the diagnosis. The response to drugs in the depersonalization syndrome is very characteristic because the condition is highly resistant to sedation. Hypoglycemic therapy is likewise ineffective. The choice of treatment is electro-anoxia. Secondary symptoms such as sleeplessness and loss of appetite may be relieved by adjunctive therapy.

ON THE ETIOLOGY OF DEPERSONALIZATION.

Iago Galdston. J. Nerv. & Ment. Dis. 105:25-39, January 1947.

Stockings in his paper on the depersonalization syndrome in the January 1947 issue of the *Journal of Mental Science* (abstracted in this issue) has indicated the clinical course of this disorder and explains it physiologically as a dysoxia of the thalamic centers and their cortical connections. This prevents proper relationship of the self to the external world. Galdston in the present discussion attacks the problem from a psychologic viewpoint. Ego relationship with reality are obviously disturbed. The integrated function of the Ego is such as to service and preserve the Super-ego in its relation to the Id so that the personality of the individual can best be served. The Ego then is essentially a function, and the integrity of the Super-ego and the Id with respect to reality becomes directly dependent upon it. According to the author, therefore, all psychopathology is a disorder in the intergration of the Ego. Disruptive factors that can affect the intergrated function of the Ego bring about a psychopathic condition. "Deep depersonalization is a degradation in the intergrated functions of the Ego."

Galdston points out that distinction must be made between depersonalization as an entity and that which accompanies other psychiatric disorders. As a matter of fact all mental disturbances show some degree of disturbances in the relationship of the personality to reality. The typical disorder in which depersonalization is most noteworthy is that of schizophrenia. Depersonalization is the forerunner of the dissociative process which is the essential element of schizophrenia. The individual who suffers from a simple depersonalization process has insight and knows that things about him have not actually changed but that they *seem* to him to be changed. The schizophrenic, on the other hand, believes the world about him has actually changed.

Failure in the integrative process may be due to one or more of four causes. First, somatic disease and physiologic disturbances which are frequently of a toxic variety. Second, deficiencies both relative and absolute in the ability of bringing about a proper integration between physical and functional endowments. The constitutional element in this case is comparatively large. Third, the integrating mechanism may be so overwhelmed by the violence of the stress to which the personality is subjected that the mechanism cannot function adequately. Fourth, the integrated functions may not be brought into play with sufficient force to meet the eventuality.

Psychic integration is mediated not only through neural elements and structures but there is also an architectonic scheme in the structure of maturation which is necessary to bring about integrative function. In other words, certain patterns of neural response must be built up so that situations and stresses may be met by proper integration of function. Pure cases of depersonalization fall under the fourth category mentioned above. The individual desires to obtain infantile satisfactions within the framework of adult existence and failing this depersonalization begins.

The author believes that the psychoanalysts in their study of depersonalization have paid too much attention to the episodic aspects of their cases. There is a failure in understanding the true nature of disintegration of the Ego function that is present not only in this disorder but in the broad field of psychoneurosis in general.

ORAL AND ANAL TENSIONS ASSOCIATED WITH DUODENAL ULCER.

R. W. Pickard. Psychoanalyt. Rev. 35:1-13, January 1948.

The greater portion of the paper is taken up with the citation and discussion of a case of perforated duodenal ulcer. Some features of the case were atypical and included unusually long periods of normality succeeded by attacks of constipation and vomiting during the height of the ulcer formation whereas the symptoms of an obsessional melancholia ushered in the healing process. In other words, the ulceration seemed to be a portion of a psychosomatic illness of cyclic character.

The theory that disturbances of the nervous system may be associated with ulcer formation needs no confirmation. Stresses in the patient's life are brought about by unusual emotional tensions. These are discovered to precede hematemesis and perforation. The prevailing emotional state is that of worry and anxiety. The typical ulcer patient is of distinct personality pattern. He is overly conscientious, is of the asthenic type, aggressively alert but constantly worrisome and pursued by discontent. Considerable frustration and resentment are present. They may be suppressed or they may come out in the form of hostility. The patient feels quite insecure and therefore is on the defensive. The inward turning of aggression has been found to be fixated at the oral and anal levels. Tension states are dug up so that a regression to infantile levels occurs. The aggressiveness is directed towards the gastro-intestinal tract. Organic

breakdown of the mucosa accompanied by constipation and vomiting result. The attacks are inclined to be cyclic in nature. The psychologic picture is that of obsessional melancholia.

Sociology and Anthropology

THE SOCIOLOGICAL ASPECTS OF HOMOSEXUALITY.

W. Norwood East. Medico-Legal J. 15:11-23, Part I, Jan.-Mar. 1947.

A discussion of this intricate subject is approached under the headings of Social Factors, Male Homosexuality, Homosexuality in Women, and the Legal Position with Regard to Offenders. The sociologic factors are discussed by East whereas the other topics are discussed by John Mackwood, Letitia Fairfield and G. D. Roberts in that order.

Etiologic factors are well known. The emphasis that should be placed upon the constitutional aspects of homosexuality is difficult of determination. Certainly some families exhibit an unusual amount of homosexuality. The most important environmental factor is early seduction by homosexual men. The author does not comment upon the fact that many boys drift into these relationships but attain heterosexuality at a later age without apparently any untoward effects. Other boys continue to indulge in homosexual practices throughout life. This type may be constitutionally determined. The onset of homosexual practices may occur at almost any age. It is a well-known medical fact that many latent homosexuals are unaware of their condition throughout the greater part of their life. Also it is a well-known fact that a homosexual man may display interest and a considerable amount of sexual activity towards a woman. They may even be married and have children. The majority of homosexuals are not given to perverse acts. Even male prostitutes are not necessarily homosexual and can usually give up the life of prostitution readily. Imprisonment has no effect upon homosexual behavior. The condition is even highly resistive to psychotherapy.

Mackwood emphasizes the harm done to the homosexual by the revengeful attitude of the community. There is a peculiar distrust and repulsiveness toward the homosexual that leads to his ostracism, which is of far more concern to the homosexual as an individual than any shame he might have for his sexual deviation. Attention is called to the defective super-ego in these cases and that similar conduct not of a sexual nature, because of defective super-ego, is countenanced by society. The author believes that many of

these cases have been cured by individual psychotherapy. Only a small group, however, are amenable to treatment. The patient must show strong desire to get well and to cooperate to the fullest with the therapist. Anxiety is the cardinal sign of a case being ready for treatment since it indicates worry, shame and guilt.

Fairfield approaches the problem as it affects women and children. Homosexuality in women differs from that in men to the extent that in the former the condition may be so deeply unconscious as to become unrecognizable by the victim. Women associate with each other in pairs much more readily than is the case with men. Such association does not bring with it any social opprobrium, whereas it permits the satisfaction of homosexual tendencies even though perverted practices may not be indulged. It is difficult to believe that such association in the long run brings about any undesirable results. The public must be educated to view the situation much more tolerantly than is its wont.

Roberts calls attention to the strictness of the law towards these so-called offenders. In the early days of the nineteenth century penal servitude for life was common. The bench has had great difficulty in realizing that the homosexual is biologically different from the usual run of men and women and to that extent cannot be held accountable for his acts. The abhorrence with which homosexual practices are dealt is probably due to a more or less instinctive realization on the part of the public that its own racial continuance is being jeopardized.

MORAL JUDGMENT. A STUDY IN RACIAL FRAMES OF REFERENCES.

Melvin Seeman. Am. Sociologic. Rev. 12:404-11, August 1947.

Methodology rather than content is the basis of exploration utilized in this study. Six situations are presented to the subject, the basis of which in each case is a course of conduct in which a moral judgment must be made. The response is affirmative, or negative, or uncertain. For example, the first situation is that in which a husband has to be away from home on business for prolonged periods. Is it wrong for his wife to entertain at such times a man who is the family's best friend? In each of the situations, justification for the conduct is given by the individual. The response of males to female question and vice versa are compared. The findings indicated that there is relatively little difference in attitude between the sexes regarding the moral judgment situations presented. Comparison with similar judgments made a number of years ago indicates marked

differences in judgments. The implication is that the double standard morality has just about been wiped out.

The second step in the methodologic study consists in the selection of two sets of figures on the basis of a Negro-white pair for each of the six situations. Judges compare the responses with respect to age, social class, general emotional tone and attractiveness so that racial content might be estimated. Thus any given student responds to either the white or the Negro frame of reference, but not to both. The less prejudiced group showed in this study more of a difference to white as against Negro reference.

The first type of test given focuses upon the situational frame as a variable. The viewpoint taken is that moral attitudes are fixed attributes of the person. The second method utilized is on the basis that those more prejudiced against the Negro will exhibit a sufficiently different pattern of response to moral judgment situations involving Negro persons than white persons, whereas the relatively unprejudiced groups will not show such differential. The author suggests that these technics may be very useful for exploring the relationship of moral judgment to social processes.

THE AMERICAN FAMILY. PROBLEM OR SOLUTION.

Reuben Hill. Am. J. Sociol. 53:125-30, September 1947.

The history of America with the problems of pioneering in a new country, is one of growth, hardship and progress. Marriage and raising of families has a high place in that progress. At the present time there are more marriages and divorces than at any time during the history of the country, which of course is a direct reflection upon the general unrest. Since the individual can live more economically and with less stress in the single state than he can when married, the author raises the question as to the reason for so many marriages in these times. The answer is found in the fact that certain basic elemental needs can be met only through the formation of the family group. These include affection, intimate response, recognition, expression of personality and security. Marriage fails if it does not provide these responses to needs. Stress is placed upon integration and adaptability in order to meet crises and stress. It is through the mechanism of a family that a simple mode of life can be attained.

The family group during the present time is in a transitional stage in which a certain amount of disorganization is taking place. The author points out clearly that disorganization must precede

reorganization so that a high degree of stabilization can be attained by the process. The sequence of events as he outlines it is as follows: First, the family encounters a crisis such as the death of one of its members, unemployment, war separation, desertion, divorce. Second, acute disorganization for a brief time may lead to such reactions as apathy towards the situation, the need for seeking outside compensation or a certain amount of panic with depression. Third, long-time reactions as a result of the disorganization may require an involved struggle to attain a livable balance. Lastly, reorganization brings about new routines with a higher degree of stabilization or the unfavorable results may ensue in which the family group becomes more submissive and dependent. The present day family life is in the intermediate stage of disorganization. The family instability so characteristic today is a precursor to a family unity in the future based upon affection and loyalty in a smaller more personalized family association. The resultant will not be a fixed quality but it will be subject to change which is cumulative in nature and which in turn will bring about another sequence of crisis-disorganization-reorganization.

Male dominance in the family group is a semipatriarchal form in which the husband provides for the family and the wife takes care of the home and the children. In former times the mold was firmly set along these lines. Today a compromise measure is permitted in which the woman may assume a much more cultural role in the family group, may even become a dominant figure economically, and is much less subservient, than her predecessor. This equating of the members of the group gives great promise as to the potential reorganization when it occurs. The family of tomorrow will be an improved small group insuring the maximum self expression of its members and the integrity and loyalty of the group as a whole.

Medicine and Biology

THE MODERN CONCEPTS OF CARDIAC NEUROSES.

N. Stuart Gilbert. M. Rec. 160:739-42, December 1947.

The clinical picture of cardiac neuroses, according to the author, is due to a spillover of afferent impulses into the hypothalmus which causes an imbalance and results in a discharge into the autonomic nervous system controlling the cardiac and vascular mechanisms. Three forms of cardiac neuroses are classified, adolescent, adult and psychosomatic forms.

The adolescent type of cardiac neurosis is most commonly encountered as neurocirculatory asthenia. The onset is sudden and occurs between the sixteenth and eighteenth year of life. From vigorous health the patient suddenly enters into a state of cardiac distress, irregular heart action, sweating, dizziness and a peculiar type of dyspnea. During this span of life, the adolescent is subject to many conflicts, often moral in nature. A struggle for adjustment between the personality and newly awakened sex activities is taking place. Under such conditions anxiety is readily engendered. The author is of the opinion that the approach to the patients should be prophylactic, and that the routine pleasures which they enjoy should not be disturbed. They should continue in their regular occupations and should not be allowed to become sedentary, for deeper psychologic fixations will then occur. Tobacco and alcohol are not contraindicated. He urges the use of a short and superficial analysis. A case report was briefly given.

The adult form of cardiac neurosis represents the middle-aged group, usually of high cultural levels. There is no true anxiety arising from a deeply-rooted neurosis but rather the individual becomes unable to meet the complex demands upon him made in every day life. He shows explosive tachycardia with dyspnea and a feeling of chest oppression. Since these symptoms may be found also in organic heart disease or thyrotoxicosis, differential diagnosis must be made. The premature ventricular systoles frequently encountered in adult cardiac neurosis must likewise be differentiated from both paroxysmal tachycardia and paroxysmal auricular fibrillation. At times the blood pressure becomes quite variable in the adult cardiac neurosis. Since the patient is neurotic a great deal of attention will be aroused as to his blood pressure and he may become so preoccupied with the readings as to become hypochondriacal. The condition of tachycardia accompanying blood pressure changes, sensitizes the patient to the disorder. The author cites a case report.

The cardiac psychosomatic neurosis in contrast to the two foregoing types, involves an actual cardiac pathology. Superimposed upon this is a cardiac neurosis of varying degrees. The condition arises out of the fact that the patient has ascertained he has heart disease and has become so disturbed thereby that he has developed considerable anxiety and overevaluates the seriousness of his condition. He becomes excessively worried and spends too much time in thinking about his heart condition. The therapeutic approach is that of assurance, the introduction of relaxation technic and occasional sedation.

THE EXPERIENCE OF DIZZINESS.

Richard D. Loewenberg, Bakersfield, Calif. Arch. Otolaryng. 46:269-81, Sept. 1947.

Every physician is faced daily with the universal symptom of dizziness, but contrary to general belief, a deeper understanding of the psychosomatic approach is not easily acquired. Although other symptoms like pain and anxiety have been much investigated in their inner aspects, there exists much less interest in the experience of dizziness. A recent symposium on this subject in Chicago had no neuropsychiatrist as participant. Dizziness, as a syndrome, claims the same challenge for the otologist as does hypertension for the cardiologist or dysmenorrhea for the gynecologist. The central position of the vestibular apparatus as "unifying factory among the senses" (Schilder) manifests itself not only as a local symptom, but also as a response and reaction of a personality in which sometimes defenses of a whole lifetime become visible. Vascular, aural, subcortical mechanisms can excite the vestibular apparatus through physical, bodily and psychologic stimuli. The psychosomatic interrelationship is not obvious or superficial and cannot be easily recognized. It is anchored deep in the past. It is not entirely a matter of the outside pathogenic factor to which the organ system of the body responds with reactions. Thus, the picture of the disease can be modified by the whole organism. Tissue pathology and psychopathology are inseparable, each a different aspect of an underlying disturbance of function. The practical significance of such an approach for insurance cases and aviation medicine is discussed.

Self observation of physiologic events has always contributed to the science of medicine and has been practiced by exact natural scientists. It is a legitimate enlargement of the clinical picture and reveals more regular laws of inner experience than is usually realized. It should not be confused with self analysis and the latter's pitfalls, although it may well contribute material for others' interpretation.

A self observation of serous labyrinthitis is given in detail and compared with the same patient's experiences of migraine and motion sickness. The much claimed close relationship of fainting and dizziness is questioned; that fears and frustrations are precipitating factors is illustrated from other observations.

Careful questioning of dizzy patients confirms that they experience different kinds of dizziness, although they might find it hard to verbalize their feelings. The rotary vertigo of the acute spells and the postural dizziness are distinct entities for the patient.

The semantic discussion of the etymology of the term "dizziness" in different languages confirms the belief that it is not incidentally used simultaneously to express both the physical and the mental-

moral loss of equilibrium. Modern psychoanalytic theories are reviewed, which connect the early infantile kinesthetic impressions of instability with the sensations of disturbed equilibrium of later life, revived by the mental-moral vacillations arising from anxiety and frustrations. The question whether certain personality types are predisposed toward vestibular reactions is considered.

Any psychosomatic investigation burdens the physician with an additional responsibility often far beyond his patience and time. New interest in an old problem proves that it is not quite as settled as was sometimes believed. The otologist and the neuropsychiatrist cannot afford the enviable selection of their patients as practiced by some modern psychotherapeutic schools. Being first and last a physician, he has to help those who ask for it. When he is aware of the whole range of reversible to irreversible vestibular attacks, he will be better able to evaluate all possible contributing factors for a successful treatment.

Author's abstract.

Announcement

After a number of preliminary meetings, dating back to May 15, 1946, the first formal meeting of the Washington Society for the Advancement of Psychotherapy, Inc. (no connection with any other organization) took place on January 16, 1947.

A constitution was adopted, and on June 6, 1947, the Society was incorporated under the laws of the District of Columbia. With it was also organized and incorporated the Washington Institute for Psychotherapy. The officers elected are: Louis S. London, M. D., President; Leopold E. Wexberg, M. D., Vice President; Benjamin Karpman, M. D., Executive Director and Secretary; Philip Litvin, M. D., Treasurer. While the present activities are local, the future plans of the Society include organization of like groups in other cities with the eventual formation of a Federation.

As stated in the Constitution, the object of the Society is to advance knowledge in the field of psychotherapy. It proposes to do this by joining together all the workers in psychotherapy, not limiting its scope to any one school of therapy; and by discussions, lectures, institutes, publications and other forms of dissemination of knowledge and experience.

Active membership is limited to Doctors of Medicine who are psychiatrists, have a minimum of ten (10) years of actual experience in psychotherapy, have been recognized as having achieved an unquestioned reputation in psychotherapy and who, at the time of their application for and during their membership, devote their

entire time to the clinical practice of psychotherapy. Provision has also been made for associate members who are either physicians in training in psychotherapy, or other medical practitioners interested in psychotherapy but not eligible for active membership. Affiliate membership is open to psychologists, educators, social workers, nurses, medical students, lawyers, ministers and other nonmedical people who have an active and legitimate interest in psychotherapy.

The following is a statement of Principles adopted at the last meeting:

I. *Definitions and Delimitations:*

In a *general* sense, psychotherapy is the science and art of systematic treatment of clinical disease and behavior disorders by any psychic means, aimed at so influencing the patient as to lead to the correction or amelioration of the abnormal reactions. In its more *specific* meanings it comprehends directed and planned management, aimed against the basic underlying causes of the illness.

The above definitions encompass essentially two forms or approaches, to wit, minor and major psychotherapy.

Under *minor psychotherapy* are grouped all those efforts which, while aiming at controlling the disease, do so by superficially influencing the symptomatology without reaching or changing the basic causation.

Under *major psychotherapy* are subsumed all those efforts, which, essentially genetic and dynamic, attempt to cure the disease or disturbed behavior, by radical removal of the basic pathology.

Through utilization of intensive, progressive and orderly attacks by recognized, well tested and efficient methods, it attempts, through favorable personal influences and manipulations of the environment, to have the patient gain insight and enable him to resolve his emotional conflicts which are the cause of his symptoms, thus helping him toward making a superior mature adjustment at a more normal and socially acceptable level.

The following are briefly the methods of both minor and major psychotherapy.

1. *Minor Psychotherapy:*

(a) Suggestion (with or without hypnosis), Persuasion, Reassurance, Directive Treatment, Guidance and Counseling.

(b) Rearrangement of Patient's life (Removal of external stresses and tensions, Relaxation, Occupational Therapy, Development of hobbies, etc.; providing socially acceptable outlets for unhealthy emotions, etc.)

(c) Group Psychotherapy.

2. *Major Psychotherapy:*
   (a) Deep Psychotherapy—Orthodox Freudian Psychoanalysis, and its minor modifications.
   (b) Brief Psychotherapy, or active psychoanalysis (Stekel, Ferenczi, Horney, et al.)
   (c) Abreaction Methods (Breuer, Frank, Grinker).
   (d) Individual Psychology (Alfred Adler).
   (e) The Will Therapy (Rank).
   (f) The Analytic Psychology (Jung).
   (g) The System of Von Hattingberg.
   (h) Objective Psychotherapy (Karpman).

II. *The Scope:*
   1. To clearly delimit the field of, and establish the indications for, psychotherapy in medicine and psychiatry.
   2. To differentiate psychotherapy from other methods of psychiatric treatment. Pharmacologic, physical and mechanical measures are viewed here as accessory forms of therapy and only of symptomatic value.
   3. To place particular emphasis on the patient as an integrated person rather than on the diseased organ, and on the basic disease rather than on its symptoms.

III. *Specific Objectives:*
   1. To foster and encourage the early psychiatric diagnosis and treatment of patients, particularly of those who can be treated at an ambulant and working level.
   2. To expand the facilities for psychotherapy so that the treatment may become available to all classes and types of patients.
   3. To encourage neglected communities to develop psychotherapeutic facilities.
   4. To emphasize the importance of differential psychotherapeutic approach in the treatment of various psychiatric groups, types and conditions.

IV. *Relation to the Medical Profession:*
   1. To interpret the meaning of psychotherapy, as a specialty in its own right, to the medical world in order to explain the surgeons, internists and general practitioners that the use of psychotherapy requires a technic which can be learned and which is just as essential for psychotherapeutic practice as is surgical technic for a laparotomy.
   2. To facilitate inter-change of opinions regarding the results and the psychotherapeutic management of patients referred by the general practitioner.

3. To convey to the medical profession the importance of psychotherapy, its advantages and limitations, its relation and contribution to the general practice of medicine and its various subdivisions and specialties.
4. To sponsor an educational program on psychotherapy which will be accessible to everybody in need of it for professional purposes.
5. To offer and provide medical societies with competent psychotherapists to stimulate discussion of their problems from the standpoint of psychotherapy.
6. To assist physicians in recognizing the early psychiatric factors which tend to precipitate the onset of many mental and nervous disorders, such as exaggerated character traits, personality anomalies, antisocial reactions and the variety of somatic disturbances which have a purely functional psychogenic aspect.
7. To aid the physician to better understand the underlying factors that are responsible for the chronicity of his patient's psychiatric symptoms.

V. *Training and Teaching:*

1. To pursue a campaign for the inclusion of psychotherapy as a major study in medical schools to be taught by a competent well trained staff, and to interest those capable of teaching psychotherapy to participate actively in the program.
2. To encourage the adequate training of all physicians interested in expanding the field of usefulness of psychotherapy.
3. To establish educational media through which younger men can be trained.
4. To help the physician in the clinical study of his cases, especially psychosomatics, and to assist him in cultivating a deeper insight into his patient's personality make-up and to clarify for him the concept of psychodynamics.

VI. *Standards:*

1. To foster the establishment of higher standards of psychotherapy.
2. To encourage psychiatrists to attain a better training in psychotherapy, by supporting all professional educational measures in the field and the sponsoring of postgraduate study and training.

VII. *The Field:*

1. To establish a common ground for the exchange of knowl-

edge and experience in the field of psychotherapy, unbiased and nonsectarian. To foster the exchange and dissemination of knowledge with reference to psychotherapy among all, however divergent, schools of psychotherapy and not limit it to one school of thought. It is felt that actual progress is only possible where different schools of thought meet and where a new synthesis may arise from the strife of contradictory opinions.

2. To conduct the affairs of the Society on a broad eclectic platform on which the variety of existing viewpoints and clinical approaches to psychotherapy may be discussed with complete freedom and without restrictions in the nature of unbiased forums.

VIII. *Dissemination of Knowledge:*

1. To publish from time to time material that will aid all practitioners in caring for persons whom psychotherapy will benefit.
2. To stimulate original research so that comparative results may be used for the benefit of all.